



COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

2017–2019 Quality Strategy

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Executive Summary

The Commonwealth of Virginia Department of Medical Assistance Services (DMAS) developed this Medicaid Comprehensive Quality Strategy in accordance with the Code of Federal Regulations (CFR), at 42 CFR §438.340.¹ DMAS developed the Quality Strategy to continually improve the delivery of quality health care to all Medicaid and Children’s Health Insurance Program [CHIP]) recipients served by the Virginia Medicaid managed care and fee-for-service (FFS) programs. DMAS’s Quality Strategy provides the framework to accomplish its overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality throughout the Virginia Medicaid and CHIP system. The Quality Strategy promotes the identification of creative initiatives to continually monitor, assess, and improve access to care, and quality, satisfaction, and timeliness of services for Virginia Medicaid and CHIP recipients.

DMAS Responsibilities

The Quality Strategy’s purpose, goals and objectives, scope, assessment of performance, interventions, and annual evaluation are detailed in this document.

DMAS maintains ultimate authority and responsibility for the maintenance and annual evaluation of the Quality Strategy. DMAS updates the Quality Strategy at least every three years and as needed based on MCO performance; stakeholder input and feedback; achievement of goals; changes resulting from legislative, State, federal, or other regulatory authority; and/or significant changes to the programmatic structure of the Virginia Medicaid program.

To demonstrate compliance with the Centers for Medicare & Medicaid Services (CMS) Quality Strategy requirements in 42 CFR §438.340 published in May 2016, DMAS created a crosswalk (Attachment C) that lists each of the required elements of state quality strategies, and the corresponding section of the DMAS Quality Strategy and, where applicable, MCO contracts that address the required elements. An overview of the CMS regulations for the managed care State quality strategy can be accessed at: <https://www.law.cornell.edu/cfr/text/42/438.340>.²

Scope of Quality Strategy

The following are included in the scope of the Quality Strategy:

- All Medicaid and CHIP managed care recipients in all demographic groups and in all service areas for which the MCOs are approved to provide Medicaid and CHIP managed care services.
- All aspects of care—including accessibility, availability, level of care, continuity, appropriateness, timeliness, and clinical effectiveness of care and services covered by DMAS’s Medicaid managed care and CHIP programs.
- All aspects of the MCOs’ performance related to access to care, quality of care, and quality of service, including networking, contracting, and credentialing; and medical record-keeping practices.
- All services covered—including preventive care services, primary care, specialty care, ancillary care, emergency services, chronic disease and special needs care, dental services, mental health services,

diagnostic services, pharmaceutical services, skilled nursing care, home health care, prescription drugs, and long-term services and supports.

- All professional and institutional care in all settings, including inpatient, outpatient, and home settings.
- All providers and any other delegated or subcontracted provider type.
- All aspects of the MCOs' internal administrative processes related to service and quality of care—including customer services, enrollment services, provider relations, confidential handling of medical records and information, case management services, utilization review activities, preventive health services, health education, information services, and quality improvement.

History and Purpose of the DMAS Quality Strategy

History

42 CFR §438.340 requires states with Medicaid managed care to have a written quality strategy. DMAS published its first quality strategy in June 2005. The strategy was updated in May 2011 to include the CHIP managed care delivery system and to provide a framework for the five-year period through 2015. In December 2015, DMAS issued Addendum 1 (Addendum) to the 2011–2015 managed care Quality Strategy as a companion to the previously published second edition. This Addendum was the result of the May 2015 release of the Proposed Rule to modernize and update the federal Medicaid managed care regulations. It addresses the progression of, and impending changes to, managed care quality in Virginia. The Addendum serves to extend the 2011–2015 DMAS Quality Strategy to cover the gap period until the third edition of the Quality Strategy is developed and approved. The third edition, an updated comprehensive Quality Strategy, was planned to be developed and published subsequent to the release of the Medicaid and CHIP Managed Care Final Rule in 2016.

This document is the third edition of DMAS's Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy for calendar years 2017–2019. It builds on the Quality Strategy Addendum currently in place as an extension to the 2011–2015 DMAS Managed Care Quality Strategy 2nd Edition. This third edition aligns with the requirements detailed in the revised federal regulations, specifically 42 CFR §438.340. The final rule issued by the Centers for Medicare & Medicaid Services (CMS), Health and Human Services (HHS) was published in the Federal Register on May 6, 2016, and is hereinafter referred to as the "new federal regulations." This final rule is the first update to Medicaid and CHIP managed care regulations in over a decade. The health care delivery landscape has changed and grown substantially since original Medicaid and CHIP managed care regulations were published in 2002. The new federal regulations advance DMAS's mission of better care, smarter spending, and healthier people. According to 42 CFR, the new federal regulations (final rule):

... modernizes the Medicaid managed care regulations to reflect changes in the usage of managed care delivery systems. The final rule aligns, where feasible, many of the rules governing Medicaid managed care with those of other major sources of coverage, including coverage through Qualified Health Plans and Medicare Advantage plans; implements statutory provisions; strengthens actuarial soundness payment provisions to promote the accountability of Medicaid managed care program rates; and promotes the quality of care and strengthens efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries. It also ensures appropriate beneficiary protections and enhances policies related to program integrity. This final rule also implements provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and addresses third party liability for trauma codes.³

The new federal regulations expand the scope of the State Quality Strategy to address the additional requirements in the following five areas:⁴

- Plan for improving quality of care and services
- Standards for network adequacy and availability of services
- Transition of care policy
- Identifying, evaluating, and reducing health disparities
- Identifying persons needing long-term services and supports and persons with special needs

Purpose

Consistent with its mission, the purpose of DMAS's Quality Strategy is to:

- Establish a comprehensive quality improvement system that is consistent with the National Quality Strategy and CMS Triple Aim to achieve better care for patients, better health for communities, and lower costs through improvement in the health care system.
- Provide a framework for DMAS to implement a coordinated and comprehensive system to proactively drive quality throughout the Virginia Medicaid and CHIP systems. The Quality Strategy promotes the identification of creative initiatives to continuously monitor, assess, and improve access to care, clinical quality of care, timeliness, member satisfaction, and health outcomes of the population served.
- Identify opportunities for improvement in the health outcomes of the enrolled population and improve health and wellness through preventive care services, chronic disease and special needs management, and health promotion.
- Identify opportunities to improve quality of care and quality of service, and implement improvement strategies to ensure Virginia Medicaid and CHIP recipients have access to high quality and culturally appropriate care.
- Identify creative and efficient models of care delivery that are steeped in best practice and make health care more affordable for individuals, families, and the State government.
- Improve recipient satisfaction with care and services.

Blueprint for the Future

DMAS's vision for quality extends beyond the Quality Strategy for 2017–2019. This Quality Strategy serves as the blueprint for developing a dynamic approach to assessing and improving the quality of health care and services furnished by the managed care and FFS entities and providers. The mechanisms for assessing quality, timeliness, and access to care will vary across the Medicaid programs in Virginia; therefore, this quality strategy is tailored to incorporate these variances while ensuring an integrated strategy overall. This strategy requires a succession of incremental steps that DMAS will pursue to achieve these quality objectives. The actions and plans outlined herein lay the necessary groundwork for an evolving strategy by establishing a strong foundation for quality governance and a comprehensive data analytics strategy.

Quality Governance

In 2017, DMAS established an integrated agency-wide quality governance structure with the creation of a Quality Steering Committee with representatives from Integrated Care, Health Care Services, Provider

Reimbursement, and the Office of the Chief Medical Officer. The Quality Steering Committee operates under the direction of DMAS Senior Leadership.

The mission of the Quality Steering Committee is to provide cross-agency governance to support the quality delivery of health care to all of the Commonwealth's Medicaid programs (e.g., CCC/CCC Plus, Medallion 3.0/4.0, and fee-for-service [FFS]). The scope of authority includes issue resolution, idea development, setting policy direction, making strategic recommendations (e.g., priority projects and measurement development), and aligning quality priorities with other agency priorities. The scope excludes issues related to compliance, program, and systemic inefficiencies.

Data Analytics Strategy

The proactive identification and resolution of issues related to health care quality is dependent upon complete, accurate, and timely data. DMAS's strategy for clinical data focuses on automation, connection, and information. DMAS's investment in an enterprise-wide data warehouse with in-house data analytics expertise is described in the Data Strategy for the Near Future section of this quality strategy. Additionally, through contracting and increased oversight, DMAS has worked to ensure that the participating managed care organizations (MCOs) and FFS providers submit accurate and timely administrative and clinical data.

Overview of the Current Environment Shaping DMAS's Quality Strategy

Medicaid

Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Medicaid is administered by states according to federal requirements. The program is funded jointly by states and the federal government.

In Virginia (a.k.a., the Commonwealth), Medicaid plays a critical role in the lives of over a million Virginians, providing access to health care for the most vulnerable populations. The impact of Medicaid extends far beyond traditional health coverage to include comprehensive services such as behavioral health and long-term services and supports (LTSS). Medicaid is the largest payer of behavioral health services in the Commonwealth, providing inpatient and outpatient services that support quality of life in the community for those in need of behavioral health support. Medicaid is also the primary funder for LTSS, making it possible for thousands of Virginians to remain in their homes or to access residential care when needed.⁵

Children's Health Insurance Program⁶

The Children's Health Insurance Program (CHIP) provides health coverage to eligible children through both Medicaid and separate CHIP programs. CHIP provides low-cost health coverage to children from birth to 18 years of age in families that earn too much money to qualify for Medicaid. In some states, CHIP covers pregnant women. Each state offers CHIP coverage and works closely with its state Medicaid program. CHIP is administered by states according to federal requirements. The program is funded jointly by states and the federal government.

The Department of Medical Assistance Services (DMAS)⁷

The Department of Medical Assistance Services (DMAS) is the Virginia State Agency that administers all Medicaid and Family Access to Medical Insurance Security (FAMIS) health insurance benefit programs in the Commonwealth. Medicaid is delivered to individuals through two models. As of November 2016, 75 percent of Medicaid enrollees received their benefits through managed care and 25 percent of enrollees participated in Medicaid through the FFS model. Virginia has been increasing its use of the MCO model because of the value it provides enrollees and the Commonwealth. Families and individuals meeting income and other eligibility requirements may be eligible to receive health benefits through a variety of programs. These include programs for children, FAMIS and FAMIS Plus (children’s Medicaid); programs for pregnant women, FAMIS MOMS and Medicaid for Pregnant Women; the Governor’s Access Plan (GAP), a program for adults with serious mental illness; and Plan First, which provides limited benefit Family Planning Services. It should be noted that FAMIS and CHIP programs are the same and the terms may be used interchangeably throughout this document.

Mission

DMAS’s mission is to provide a system of high-quality and cost-effective health care services to qualifying Virginians and their families that far exceeds the industry standards for timeliness, access, and quality of care.

Vision

DMAS’s vision is to develop an outcomes-based quality program that focuses on the member’s health and encourages innovation in healthcare services and programs.

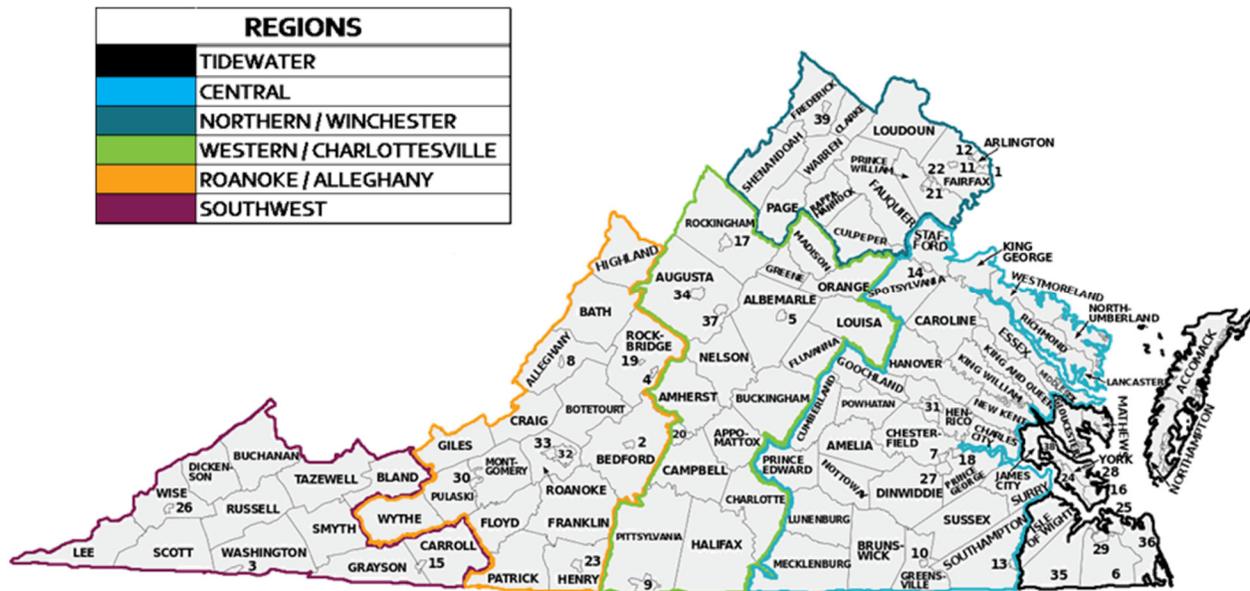
Values

- Customer Service—Operate with a high degree of customer service.
- Responses—Demonstrate integrity, responsiveness, and competency in agency actions and communications.
- Collaboration—Foster an atmosphere of effective collaboration with customers and stakeholders.
- Innovation and Accountability—Encourage agency innovation and require accountability.
- Results—Strive to ensure the provision of high-quality, efficient, patient-centered care.

Virginia Healthcare Service Regions

The map of Virginia in Figure 1 is color coded to delineate the counties included in each of the six distinct regions established for delivery of Medicaid MCO health care services provided by the two MCO models: Medallion 3.0/4.0 and Commonwealth Coordinated Care (CCC)/CCC Plus.

Figure 1—Virginia Healthcare Service Regions



Medallion 3.0 MCO Model

The Virginia Medallion 3.0 program provides health care coverage statewide to Medicaid members through a mandatory MCO enrollment mechanism for designated eligibility categories. Currently, Virginia Medallion 3.0 program covers the Low Income Families with Children (LIFC) and Aged, Blind and Disabled (ABD) populations, and two more recent expansion groups, Foster Care/Adoption Assistance (FC/AA) and the Health and Acute Care Program (HAP) population. The primary exclusions are members who are dually eligible for Medicare and Medicaid, who have comprehensive private insurance as a primary payer, who reside in nursing homes, and some members who receive services under a home and community-based waiver.

The HAP Medallion 3.0 populations will transition to the Commonwealth Coordinated Care Plus (CCC Plus) managed care program (described in the following section of this Quality Strategy) in regional phases during the first six months of contract year 2018. The ABD population will transition to CCC Plus as of January 1, 2018. At the beginning of FY 2019, the remaining Medallion 3.0 LIFC, AA, and FC populations will transition to the new Medallion 4.0 Medicaid managed care program in regional phases from August 1 to November 30, 2018.

Foster Care Program

The Department of Medical Assistance Services (DMAS) transitioned 300 foster care children into managed care in 2011 with legislative support from the Governor and General Assembly. The pilot was successful, and in 2012, the General Assembly endorsed the inclusion of children placed in foster care and those receiving adoption assistance into managed care. The goal of the expansion process was to provide improved access to preventive and coordinated health care.

Preparation to ensure a seamless transition began in 2012 and focused on three major areas: system changes at DMAS and Department of Social Services (DSS) allowed for proper identification and location of

the children; targeted outreach to local DSS staff, child placement agencies, foster care and adoptive parents; and extensive trainings and communications. In addition, the Department hired a staff member with subject matter expertise to manage and monitor the program.

With collaborative efforts between local permanency and eligibility staff members across the State and managed care organizations, over 10,000 foster care and adoption assistance children were enrolled into managed care. The program experienced huge successes and accomplishments in 2014, most notably, the transition of 4,600 foster care and 5,900 adoption assistance youth into managed care between September 2013 and June 2014. The move occurred in regional phases beginning with the Tidewater area in September 2013 and concluding with the Southwest region on June 1, 2014.

Medallion Care System Partnership (MCSP)

DMAS established the Medallion Care System Partnership (MCSP) with the goal of improving health outcomes for Medicaid members through a system designed to integrate primary, acute, and complex health services provided by contracted MCOs through Health Care Homes or other MCSP-approved arrangements. The MCSP model allows the MCO the flexibility to create and test innovative payment models, incentive structures and arrangements, and value-and-market-based programs within geographic areas, particular populations, or even at the physician practice level to determine how to bend the cost curve while improving quality.

The MCOs are required to form partnerships with providers and/or health care systems in an effort to increase participation of integrated provider health care delivery systems, improve member health outcomes as measured through risk adjusted quality metrics appropriate to the enrolled population, and to align administrative systems to improve efficiency and member experience.

Expansion of Dental Services

On March 1, 2015, DMAS expanded adult dental coverage to include pregnant women, ages 21 and over, enrolled in Medicaid and FAMIS MOMS through Virginia's nationally recognized Smiles for Children program. Both evidence-based practice and research show that receiving dental care during pregnancy can reduce periodontal disease and periodontal pathogens. Pregnant women receiving dental care may potentially reduce the transmission of oral bacteria from mother to unborn child. This plan was placed into action in hopes of decreasing dental emergencies and increasing the likelihood of mothers delivering healthy babies.

Between March 1, 2015, and September 5, 2016, the number of pregnant women utilizing their dental benefits has steadily climbed to 8,875 members. This gave pregnant women enrolled in Medicaid and FAMIS MOMS the ability to receive appropriate benefits covered by the Smiles for Children program, including diagnostic, preventive, restorative, endodontic, periodontics and prosthodontic services, along with access to nonemergency transportation services to receive dental care and medically necessary oral surgeries.

Behavioral Health Home Pilot

In collaboration with the Office of the Governor and in alignment with the Governor's plan, A Healthy Virginia, DMAS, and the Medallion 3.0 MCOs established behavioral health home pilot programs to coordinate care for beneficiaries who are insured through the Medallion 3.0 Medicaid program. The pilot became effective July 1, 2015. The Behavioral Health Home (BHH) pilot program includes adult members over the age of 21 who have a serious mental illness or a serious emotional disturbance. These health homes adopt a "whole person" philosophy for treatment that calls for team-based care of all primary,

acute, behavioral health, and some substance abuse services. Virginia uses behavioral health homes to enhance the treatment of both mental and physical health conditions and significantly decrease the level of impairment experienced by these individuals. Five of the MCOs are participating, and the pilot programs have a presence in every major region in the State.

Commonwealth Coordinated Care MCO Model

Commonwealth Coordinated Care (CCC) is a program that blends and coordinates Medicare and Medicaid benefits for approximately 30,000 Virginians. As only the third state to implement this type of coordinated care for Medicare-Medicaid enrollees, Virginia pioneered an innovative, responsive program to provide health care and long-term services and supports to people who often have very complex needs.

This program ends December 31, 2017, with the dual eligible members transitioning to CCC Plus on January 1, 2018.

Covering Complex Medical Needs of Medicare/Medicaid-Eligible Individuals

Nationwide, individuals who are dually eligible for Medicare and Medicaid typically have the highest and most complex medical needs but are often underserved by the misaligned rules and financial incentives of the two separate programs, which often results in cost inefficiency and poor health outcomes due to uncoordinated care.

CCC blends all of the benefits currently provided under Medicare and Medicaid into one plan with a designated care manager who will ensure person-centered and efficient health care services are provided. This not only makes it easier to manage the system from the beneficiary's perspective, this innovative program brings greater efficiencies and cost savings to the State's overall health care delivery system.

Virginians eligible for CCC include those who are full Medicare and Medicaid beneficiaries (meaning entitled to benefits under Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits), are age 21 or older, and live in designated regions around the Commonwealth. Individuals receiving long-term supports and services through nursing facilities and the Elderly or Disabled with Consumer Direction (EDCD) Waiver are also eligible to participate in a managed care program through CCC.

Four-Year CMS Demonstration Project

Three Medicare-Medicaid health plans, Anthem HealthKeepers, Humana, and Virginia Premier, contracted with CMS and DMAS to provide services under CCC during a four-year demonstration. The contract included provisions for person-centered care planning, interdisciplinary care teams, care coordination services, provider credentialing, access to services, unified appeals and grievances, and closely monitored quality of services. CMS and DMAS monitored health plan performance and quality by requiring the health plans to report Healthcare Effectiveness Data and Information Set (HEDIS®)⁸ data along with quarterly assessment and plan of care completion rates. In addition, the participating health plans offered supplemental benefits that are not available in the Medicaid or Medicare programs. During the demonstration, CCC was available to Virginians in five regions of the Commonwealth: Tidewater, Central, Northern Virginia, Charlottesville, and Roanoke.

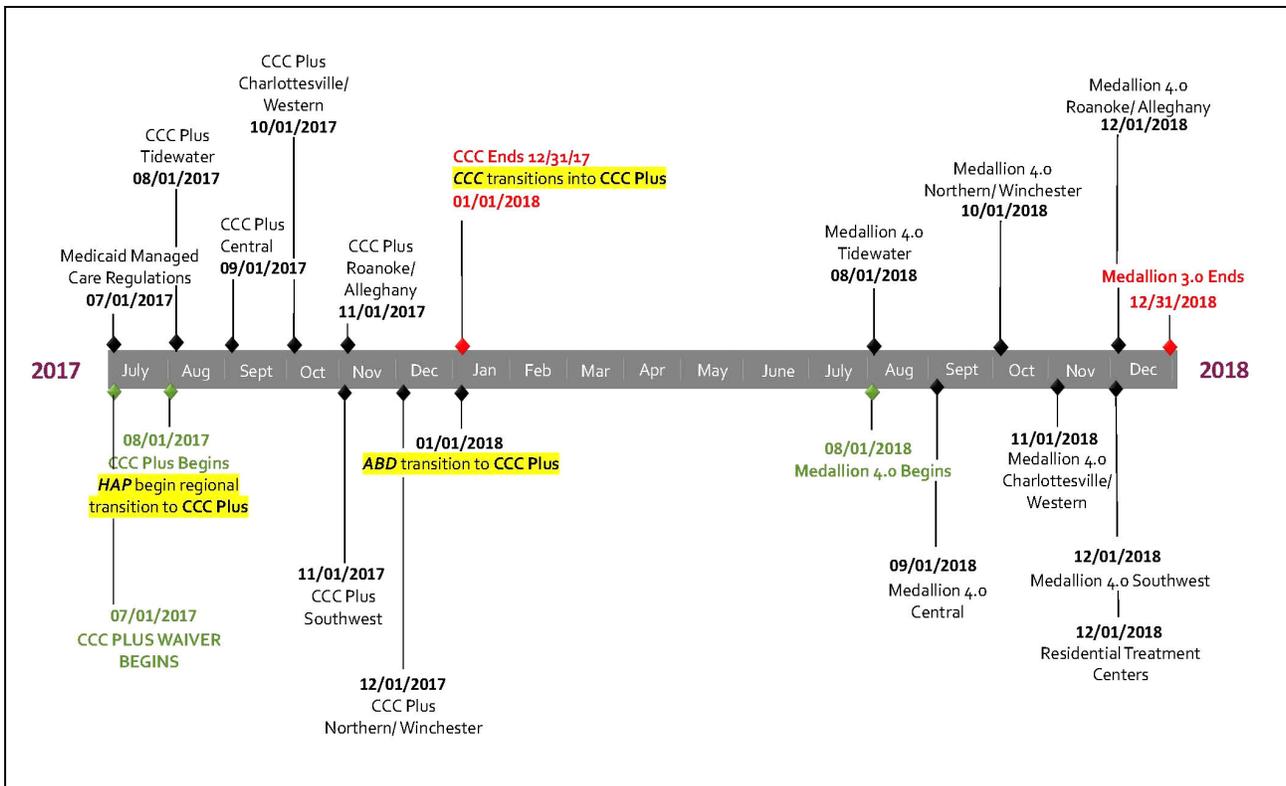
Restructuring Medicaid Managed Care in the Commonwealth

Virginia DMAS is in the process of modifying the structure of the Medicaid managed care programs, and changes are underway over the 17-month time period from July 1, 2017, through November 30, 2018. The HAP Medallion 3.0 populations will transition to the Commonwealth Coordinated Care Plus (CCC Plus) managed care program (described in the following section of this Quality Strategy) in regional phases during the first six months of contract year 2018. The ABD population will transition to CCC Plus as of January 1, 2018. At the beginning of FY 2019, the remaining Medallion 3.0 LIFC, AA, and FC populations will transition to the new Medallion 4.0 Medicaid managed care program in regional phases from August 1 to November 30, 2018.

The schedule of the transition of the Medallion 3.0 populations into the CCC Plus and new Medallion 4.0 programs affects the contract year midpoint for current Medallion 3.0 populations. The new program regions do not exactly align with the current Medallion 3.0 regions. While the county and locality definitions for Medallion 3.0 and the new programs are generally similar for the Far Southwest, Roanoke/Alleghany, and Tidewater regions, the new Medallion 4.0 regions (i.e., Central Virginia, Charlottesville/Western, and Northern/Winchester) will include counties and localities from as many as four of the current Medallion 3.0 regions.

Figure 2 shows a timeline of the important dates for the transitions from Medallion 3.0 and CCC to Medallion 4.0 and CCC Plus. The red font indicates existing program ending dates, the green font indicates new program starting dates, and the yellow font indicates transitions of existing populations from one program to another.

Figure 2—Important Dates for VA Managed Care Transitions to Medallion 4.0 and CCC Plus



Commonwealth Coordinated Care Plus MCO Model

Commonwealth Coordinated Care Plus (CCC Plus) is a new statewide Medicaid managed long-term services and supports (LTSS) program that will serve approximately 217,000 children and adults with disabilities and complex care needs across the full continuum of care. The primary goal of CCC Plus is to improve health outcomes. CCC Plus operates under a 1915 (b)(c) authority. Section 1915(c) allowed DMAS to target the eligibility and provide long-term care services delivered in community settings (HCBS) as an alternative to institutional settings for children and adults with complex care needs. Section 1915(b) allowed DMAS to mandate enrollment in managed care plans that provide these HCBS services.

Integrated Delivery Model

CCC Plus care management is at the heart of the CCC Plus high-touch, person-centered program design. CCC Plus focuses on improving quality, access, and efficiency. CCC Plus is an integrated delivery model that includes care coordination and person-centered care with an interdisciplinary team approach to provide medical services, behavioral health services, and long-term services and supports. The Model of Care Elements encompass:

- Specific approaches for vulnerable subpopulations.
- Staff and provider training.
- Provider networks having specialized expertise and use of clinical practice guidelines and protocols.
- Assessments.
- Interdisciplinary care teams.
- Individualized care plans.
- Care coordination.
- Transition programs.

CCC Plus Members and MCOs

DMAS has contracts with six MCOs (Aetna Better Health of Virginia, Anthem HealthKeepers Plus, Magellan Complete Care of Virginia, Optima Health Community Care, United Healthcare, and Virginia Premier Health Plan) to provide the CCC Plus model across the State.

Enrollment into CCC Plus is required for qualifying populations. The CCC Plus phase-in begins in August 2017, and will include Medicaid members who:

- Receive Medicare benefits and full Medicaid benefits (dual eligible), including members currently enrolled in the Commonwealth Coordinated Care (CCC) program.
- Are eligible in the Aged, Blind and Disabled (ABD) child and adult Medicaid coverage groups, including 85,920 ABD individuals currently enrolled in the Medallion 3.0 program. These individuals will transition from Medallion 3.0 to CCC Plus on January 1, 2018.
- Receive Medicaid long-term services and supports (LTSS) in a nursing facility or through one of DMAS's home and community-based services (HCBS) waivers (this includes the 9,984 home and community-based members who currently are enrolled in Medallion 3.0 for acute care services only):
 - Building Independence (BI) (acute services only)
 - Family and Individual Support (FIS)

- Community Living (CL)
- Commonwealth Coordinated Care Plus Waiver (formerly the Elderly or Disabled with Consumer-Direction [EDCD] and Technology-Assisted [Tech] waivers)

Dual Eligible Special Needs Plan

A Dual Eligible Special Needs Plan (D-SNPs) is a type of Medicare Advantage Plan. D-SNPs limit membership to people who qualify for both Medicare and Medicaid (duals). Individuals can, but are not required to, enroll in the same health plan for Medicare and Medicaid benefits. This will enhance and simplify the coordination of their benefits and reduce their burden. All CCC Plus health plans are required to offer D-SNPs in Virginia within two years of being awarded a CCC Plus contract.

Medallion 4.0 Medicaid Managed Care Program

Medallion 4.0, is the next phase of program improvements to Virginia’s managed care delivery system. The Medallion 4.0 program, through the contracted MCOs, will be the vehicle through which DMAS will drive innovations in service delivery and payment models for over 737,000 Medicaid and FAMIS members. Medallion 4.0 will be a 1915 (b) waiver program that will cover the basic Medallion 3.0 and FAMIS populations. The program themes and focus include a big quality, data, and outcome focus; maternal child health partnerships; behavioral health models; strong compliance and reporting; provider and member engagement; and innovation.

The new program will build on the strengths and experience of the 20-year Medallion program and will closely align with the new Commonwealth Coordinated Care Plus (CCC Plus) program. Together and where feasible, Medallion 4.0 and CCC Plus may streamline policies and processes related to value-based purchasing, common core formulary, data integrity, quality, etc.

Medallion 4.0 will:

- Provide new carved-in populations and services:
 - Early Intervention Services
 - Third Party Liability (TPL)
 - Community Mental Health and Rehabilitation Services (CMHRS)
- Continue to serve children, pregnant women, and parents.
- Begin covering and coordinating services, such as Early Intervention (EI) and non-traditional behavioral health services, that were previously “carved out” and paid through traditional fee-for-service Medicaid.
- Support alternate payment methods in Virginia.

The expectations of the Medallion 4.0 Program include:

- Improving quality of life and health outcomes for enrolled individuals.
- Providing a seamless, one-stop system of services.
- Facilitating communication between providers to improve the quality and cost effectiveness of care.
- Providing system-wide monitoring and quality improvement.
- Ensuring the use of culturally, linguistically, and ability-appropriate consumer and family educational materials.
- Increasing appropriate use of screening and prevention services.

Table 1—Medallion 4.0 Population Goals

Member-centered Goals	Population Health Interventions and Focus
Pregnant Women	
<ul style="list-style-type: none"> • Increase Early Prenatal Care • Increase Case Management • Increase Postpartum Care including depression screenings • Reduce Early Elective Deliveries • Reduce C-Section Rate • Improve Birth Outcomes • Increase Breast Feeding • Increase Family Planning Utilization 	<ul style="list-style-type: none"> • Increase the HEDIS scores • Implement Addiction and Recovery Treatment Services (ARTS) • More Outreach and Education • Use of Social Media • Enhance Value-Based Payments • Opportunity for Maternal Kick Payment (a supplemental payment made to managed care plans for a particular event such as childbirth).
Infants 0–3	
<ul style="list-style-type: none"> • Increase Immunizations • Increase Well Visits • Increase Early Assessments • Increase Safe Sleep • Decrease Neonatal Abstinence Syndrome (NAS) Babies • Reduce Infant Death Rate • Increase Early Detection, Screening and Intervention 	<ul style="list-style-type: none"> • Zero to Three Workgroup • Three Branch Workgroup for Reducing Infant Death Rate
Children 3–18	
<ul style="list-style-type: none"> • Increase <ul style="list-style-type: none"> – Oral Health – Vision – Well Visits – Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) • Improve Coordination <ul style="list-style-type: none"> – Department of Education (DOE) – Department of Social Services (DSS) – Virginia Department of Health (VDH) – Department of Behavioral Health and Developmental Services (DBHDS) 	<ul style="list-style-type: none"> • Special Needs Children • Trauma Informed Care • Community Mental Health Rehabilitation Services (CMHRS)
Foster Care & Adoption Assistance	
<ul style="list-style-type: none"> • Same as non-foster and adoption children 	<ul style="list-style-type: none"> • Continue health plans' agreement to work with DMAS • Plans work with State DSS as well as local DSS social worker and eligibility worker • Support foster care parents • Regional case management • Increase reporting • Seamless transitioning of children to new status

Member-centered Goals	Population Health Interventions and Focus
Adults	
<ul style="list-style-type: none"> • Increase Early Detection, Screening, and Intervention 	<ul style="list-style-type: none"> • Wellness • Chronic Diseases • Diabetes <ul style="list-style-type: none"> – Hypertension – Heart Disease – Obesity – Specialty Programs (Addiction and Recovery Treatment Services) • Behavioral Health and CMHRS • Family Planning/Long-Acting Reversible Contraceptive (LARC) §438.206 • Social Determinants of Health • Emergency Department Use • Hospital Readmissions

General Rule—Managed Care Quality Strategy §438.340 (a)

This current (third) edition of the DMAS Quality Strategy fulfills the requirement in the new federal regulations for DMAS to draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by the contracted MCOs.

The current (third) edition of the DMAS Quality Strategy addresses all of the required elements and sub-elements of a managed care State quality strategy per requirement §438.340 (a) for assessing and improving the quality of health care and services furnished by the contracted MCOs. Appendix C provides a crosswalk that lists the required elements and sub-elements for state quality strategies, per 42 CFR §438.340 (b) and corresponding sections in the DMAS Quality Strategy and the DMAS/MCO contract or request for proposal (RFP) which address each required and element.

Required* Elements Addressed in the DMAS Third Edition Quality Strategy

438.340 (b) (1) Delineating DMAS-defined network adequacy and availability of services standards

438.340 (b) (1) Adopting and disseminating evidence-based clinical practice guidelines

438.340 (b) (2) Developing goals and objectives for continuous quality improvement

438.340 (b) (3) (i) Establishing quality metrics and performance targets to measure performance improvement

438.340 (b) (3) (ii) Proposing projects to improve access, quality, or timeliness of care (PIP)

438.340 (b) (4) Conducting annual external independent review of access, quality, and timeliness of care

438.340 (b) (5) Accessing continued services upon transitions in care

438.340 (b) (6) Identifying, evaluating, and reducing health disparities

438.340 (b) (7) Using intermediate sanctions to drive improvement (primary care case manager [PCCM])

438.340 (b) (8) This element is not addressed. It pertains only to PCCMs which are not contracted by DMAS

438.340 (b) (9) Identifying persons needing long-term services and supports and persons with special needs

438.340 (b) (10) Avoiding duplication of EQR activities

438.340 (b) (11) Clarifying definition of significant change

438.340 (c) (2) (i) Obtaining Public Comment

438.340 (c) (2) (ii) Consulting with tribes

438.340 (c) (2) (iii) Updating Quality Strategy and incorporating recommendations as appropriate

438.340 (c) (3) Submitting to CMS

438.340 (d) Posting final quality strategy to DMAS website

*Although sub-elements are not listed separately, they are addressed accordingly with the corresponding elements.

Establishing Standards, Guidelines, and Definitions

Delineating DMAS-Defined Network Adequacy and Availability of Services Standards §438.340 (b) (1)

DMAS developed standards to ensure that all covered Medicaid and FAMIS services delivered through contracted MCOs are available and accessible to enrollees by having an adequate provider network. The standards address providing access to covered services through providers who are within reasonable travel time; providing the full scope of Medicaid and CHIP services; having timely access to services; and providing services in a culturally competent manner.

Provider-Specific Time and Distance Standards §438.68 (b) (1 and 2)

Provider-Specific Time and Distance by Provider Type for Medallion 4.0 and CCC Plus

Enrollee Travel Time Standard

According to federal law, a state that contracts with an MCO to deliver Medicaid services must develop and enforce network adequacy standards that include time and distance standards for provider types that include adult and pediatric primary care, OB/GYN, behavioral health, adult and pediatric specialist, hospital, pharmacy, and pediatric dental.

In accordance with the regulation, DMAS establishes time and distance standards based on provider type and the characteristics and special needs of specific Medicaid populations. To that effect, DMAS has included contractual specifications for time and distance standards in the CCC Plus and Medallion 4.0 contracts to address these distinct populations. Travel time and distance is defined per line of business and as urban versus rural. For urban areas, each enrollee will have a choice of at least two providers of each service type located within no more than 30 minutes travel time from any enrollee unless the MCO has a Department-approved alternative time standard. Travel time will be determined based on driving during normal traffic conditions (i.e., not during commuting hours). Standards are also defined for rural areas, for Medallion 4.0 and CCC Plus members.

Development of Network Adequacy Standards §438.68 (c) (1)

To set clear standards related to access to care and provider networks, DMAS identifies and quantifies the needs of major Medicaid subgroup enrollees; health and long-term services and supports (LTSS) needs, needs of current Medicaid managed care members, and the number and types of providers each participating plan's network must have to meet those needs.

DMAS uses demand for specific services based on utilization patterns derived from Medicaid and CHIP claims and encounter data available for previous periods in DMAS's Medicaid Management Information System (MMIS). For existing managed care programs, DMAS uses MCO encounter data from the past two or three years. For new managed care programs, FFS claims are the primary source of data for analyzing previous service use.

To obtain this information, DMAS uses the following types of data:

- Virginia Medicaid eligibility and capitation payment files.
- FFS data for the population covered by recent managed care program expansions.
- Health plan encounter data for the population in managed care.
- Health plan vendor payments for subcontracted services.
- Health plan encounter data for other populations, with appropriate adjustments to reflect utilization patterns of Medicaid enrollees.

Table 2—Network Adequacy Standards

Network Adequacy Standards Include (i.e., in MCO contracts)	Medallion 4.0	CCC Plus
<i>Anticipated Medicaid enrollment</i>	X	X
<i>Expected utilization of services</i>	X	X
<i>Characteristics and health care needs of specific Medicaid populations covered in the MCO, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) contract</i>	X	X
<i>Numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services</i>	X	X
<i>Numbers of network providers who are not accepting new Medicaid patients</i>	X	X
<i>Geographic location of network providers and Medicaid enrollees, considering distance, travel time, and the means of transportation ordinarily used by Medicaid enrollees</i>	X	X
<i>Ability of network providers to communicate with limited-English-proficient enrollees in their preferred language</i>	X	X
<i>Ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities</i>	X	X
<i>Availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions</i>	X	X

Development of Network Adequacy Standards §438.68 (c) (2)

In addressing standards for network adequacy and availability requirements, DMAS takes into consideration elements supporting the enrollee’s choice of provider and strategies supporting community integration of the enrollee. In addition, other elements in the best interest of enrollees who need LTSS are taken into consideration.

Exceptions Process §438.68 (d) (1 and 2)

If DMAS permits an exception to any of the provider-specific network standards, the standard by which the exception will be evaluated and approved must be/is specified in the MCO contract based on the number of providers in that specialty practicing in the MCO service area. If DMAS grants an exception, enrollee access to that provider type will be monitored on an ongoing basis and the findings will be included in the managed care program assessment report to CMS required under §438.66.

Publication of Network Adequacy Standards §438.68 (e)

DMAS published the Provider-Specific Time and Distance Standards in the Medallion 3.0 and CCC Plus contracts, available at

http://dmasva.dmas.virginia.gov/Content_atchs/mc/Medallion%203%200%20Contract%20for%202015-2016%20-%20FINAL%20Clean%20Copy%20-6-18-2015.pdf and

http://www.dmas.virginia.gov/Content_atchs/mltss/CCC%20Plus%20Final%20February%202017.pdf, respectively. Upon request, network adequacy standards are also made available at no cost to enrollees in alternate formats or through the provision of auxiliary aids and services.

To ensure that these standards are achieved and maintained, DMAS monitors and holds the MCOs to meeting these standards.

Availability of Services 42 CFR §438.206 (b) (1-7)

DMAS ensures that all services covered under the State plan are available and accessible to enrollees of MCOs in a timely manner as defined in 42 CFR §438.206. DMAS must also ensure that MCO provider networks for services covered under the contract meet DMAS network adequacy standards defined in each managed care contract. The standards below apply to the DMAS contracts with MCOs beginning on or after July 1, 2018. Until that applicability date, DMAS is required to continue to comply with §438.206 contained in 42 CFR parts 430 to 481, edition revised as of October 1, 2015.

Through the CCC Plus and future Medallion 4.0 contracts, DMAS ensures that each MCO's delivery network meets the following requirements:

- Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities.
- Provides female enrollees with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.
- Provides for a second opinion from a network provider, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.
- If the provider network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO adequately covers these services in a timely manner out of network for the enrollee, for as long as the MCO's provider network is unable to provide them.
- Requires out-of-network providers to coordinate with the MCO for payment and ensures the cost to the enrollee is no greater than it would be if the services were furnished within the network.
- Demonstrates that its network providers are credentialed as required by §438.214.
- Demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services.

DMAS ensures that each contract with an MCO complies with the following requirements: §438.206 (c) (1-3):

- Timely access. Each MCO must do the following:

- Meet and require its network providers to meet DMAS standards for timely access to care and services, taking into account the urgency of the need for services.
 - Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS, if the provider serves only Medicaid enrollees.
 - Make services included in the contract available 24 hours a day, seven days a week, when medically necessary.
 - Establish mechanisms to ensure compliance by network providers.
 - Monitor network providers regularly to determine compliance.
 - Take corrective action if there is a failure to comply by a network provider.
- Access and cultural considerations. Each MCO must participate in DMAS's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.
 - Accessibility considerations. Each MCO must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

DMAS implements contracting standards that align with the relevant federal Medicaid regulations for ensuring availability of services. Section 3.15 of the Medallion 3.0 contract states that the MCO must establish a system to monitor its provider network to ensure that the access standards set forth in the contract are met, must monitor regularly to determine compliance, taking corrective action when there is a failure to comply, and must be prepared to demonstrate to DMAS that these access standards have been met. The availability of services standards will be revised to comply with the updated federal regulations when the Medallion 4.0 contracts are executed in 2018.

The CCC Plus contract requires MCOs to ensure that the delivery system will provide available, accessible, and adequate numbers of facilities, locations, and personnel for the provision of covered services. The MCO's network will meet or exceed federal network adequacy standards at 42 CFR §438.68 and will have sufficient types and numbers of traditional and LTSS providers in their networks to meet historical need and must be able to add providers to meet increased member needs in specific geographic areas. Adequacy will be assessed along a number of dimensions, including number of providers, mix of providers, hours of operation, accommodations for enrollees with physical disabilities (wheelchair access) and barriers to communication (translation services); and geographic proximity to beneficiaries. Section 9.18 of the CCC Plus contract states that the MCO will establish a system to monitor its provider network to ensure that the access standards set forth in the contract are met, must monitor regularly to determine compliance, taking corrective action when there is a failure to comply, and must provide a quarterly report by provider type that demonstrates to the Department that these access standards are being continuously monitored by the MCO and that standards have been met.

Adopting and Disseminating Evidence-Based Clinical Practice Guidelines §438.236 (a)

State Standards for Clinical Guidelines

42 CFR §438.236 requires the State to ensure that each MCO has the structure and clinical resources for adopting evidence-based clinical guidelines for meeting the health care needs of enrollees.

To meet the CFR requirements, MCOs are contractually obligated by DMAS to:

- Provide local medical management through licensed registered nurses (RNs) or individuals with appropriate professional clinical expertise to perform case management activities.
- Have a full-time, Virginia-based medical director who is a Virginia-licensed medical doctor.
- Have medical management staffing at a level that is sufficient to perform all necessary medical assessments and to meet all enrollees' case management needs at all times.
- Ensure that practitioners are using relevant clinical practice guidelines.
- Establish the clinical basis for the guidelines.
- Update the guidelines at least every two years and initiate the review of a guideline before two years if new scientific evidence or national guidelines warrant the need for a review.
- Distribute the guidelines to the appropriate practitioners.

Examples of Clinical Guidelines in Both Medallion 4.0 Request for Proposals⁹ and CCC Plus Contracts¹⁰

§438.340 (b)(1), in accordance with §438.236

Immunizations

The MCO will cover immunizations within the most current Centers for Disease Control and Prevention (CDC) guidelines. The MCO will educate providers regarding reimbursement of immunizations and to work with the Department to achieve its goal related to increased immunization rates.

Mammograms

The MCO will cover low-dose screening mammograms for determining the presence of occult breast cancer. Screening mammograms for age 40 and over shall be covered consistent with the guidelines published by the American Cancer Society.

Accessing Continued Services Upon Transition in Care 42 CFR §438.62 (a) and (b)

The updated continuity of care regulations require DMAS to make its transition of care policy publicly available and provide instructions to enrollees on how to access continued services during a transition when the enrollee would suffer serious detriment to his or her health or be at risk of hospitalization or

institutionalization upon transition from FFS to an MCO or from one MCO to another by July 1, 2018. In addition, DMAS incorporates this requirement in the MCO contracts as evidenced by the CCC Plus MCO Accountability for Continuity of Care requirements.

CCC Plus MCO Accountability for Continuity of Care (contract section 5.14)

The MCO will provide or arrange for all medically necessary services, whether by subcontract or by single-case agreement in order to meet the needs of its members, including during care transitions to the MCO's health plan. The MCO will also work closely with the Department, other contracted health plans, and DMAS MCOs toward the goal of ensuring continuity of care for members whose enrollment changes between the MCO's plan, DMAS fee-for-service, or another CCC Plus MCO. The MCO will develop and implement strategic processes that support collaborative efforts among MCOs for smooth care transitions and that prevent a member from having interrupted or discontinued services, throughout the transition, and until the transition is complete.

The MCO must have systems and operational processes in place for sharing data to/from DMAS, reviewing the data for potential high-risk member needs, and utilizing the data to support the transition process. Transition data will include but not be limited to members' claims and service authorizations. The process shall require the MCO to, at a minimum:

- 1) Ensure that there is no interruption of covered services for members.
- 2) Accept the transfer of all medical records and care coordination data, as directed by DMAS.
- 3) Send service authorization data to support continuity of care for members transitioning between fee-for-service and CCC Plus. General Provisions, contract section 15.14.1

The MCO will ensure continuity of care for all members upon enrollment into the plan. During the time period set below, the MCO will maintain the member's current providers at the Medicaid FFS rate and honor service authorizations (SAs) issued prior to enrollment for the specified time period.

The MCO will allow a member to maintain his or her current providers (including out-of-network providers) for 90 calendar days during the regional rollout (or until a new plan is developed) starting January 1, 2018. During the continuity of care period, the MCO may change a member's existing provider only in the following circumstances:

- 1) The member requests a change;
- 2) The provider chooses to discontinue providing services to a member as currently allowed by Medicaid;
- 3) The MCO or DMAS identify provider performance issues that affect a member's health or welfare; or,
- 4) The provider is excluded under State or federal exclusion requirements.

Within the continuity of care period, the MCO will make reasonable efforts to contact out-of-network providers who are providing services to members, and provide them with information on becoming credentialed, in-network providers. (The MCO will offer single-case agreements to providers who are not willing to enroll in the MCO's provider network.) If the provider does not join the network, or the member does not select a new in-network provider by the end of the continuity of care period, the MCO will choose one for the member (with the exception of nursing facility [NF] residents).

For pharmaceutical services, the MCO will ensure that members can continue treatment of medications prescribed or authorized by DMAS or another MCO (or provider of service) for the continuity of care period or through the expiration date of the active service authorization including service authorizations approved by DMAS's Drug Utilization Review (DUR) Board. This would not preclude the health plan from working with the member and his or her treatment team to resolve polypharmacy concerns. Additionally, a member that is, at the time of enrollment, receiving a prescription drug that is not on the MCO's formulary or preferred drug list (PDL) will be permitted to continue to receive that drug if medically necessary.

Members With Service Authorizations (SAs), contract section 5.14.2

The MCO will honor SAs issued by the Department or its MCOs as provided through DMAS transition reports and DMAS's contracted entities for the duration of the SA or during the continuity of care period, whichever comes first. If the authorization ends before the initial health risk assessment (HRA) is completed, the continuity of care period continues until after the HRA is completed and a new person-centered individualized care plan (ICP) has been implemented.

If the authorized service is an inpatient stay, the financial responsibility will be allocated as follows:

- For per diem provider contracts, reimbursement will be shared between the MCO and either the Department or the new MCO. In the absence of a written agreement otherwise, the MCO and the Department or the new MCO will each pay for the period during which the member is enrolled with the entity. For provider contracts where reimbursement is based upon the diagnosis-related group (DRG), in accordance with the "Hospitalized at Time of Enrollment" section, the MCO is responsible to pay for the full inpatient hospitalization (admission to discharge), including for any member actively enrolled in the MCO on the date of admission, regardless of the member's disenrollment from the MCO during the course of the inpatient hospitalization.

If, as a result of the HRA and ICP development, the MCO proposes modifications to the member's SAs, the MCO will provide written notification to the member and an opportunity for the member to appeal the proposed modifications.

Members in Nursing Facilities, contract section 5.14.3

Members in a nursing facility at the time of CCC Plus program enrollment may remain in that NF as long as they continue to meet DMAS level of care criteria for NF care, unless they or their authorized representatives prefer to move to a different NF or return to the community. The only reasons for which the MCO may require a change in NF is if (1) the member requests a change, (2) the provider is excluded under State or federal exclusion requirements, or (3) due to one or more deficiencies that constitute immediate jeopardy to resident health or safety, per direction from DMAS, the Virginia Department of Health (VDH)—Office of Licensure and Certification (OLC) or Adult Protective Services. Such reasons are described in the DMAS Nursing Home Manual, Chapter IX, 42 CFR §488.410, 12VAC30-20-251, and at <http://www.vdh.virginia.gov/OLC/LongTermCare/survey.htm>. If it is determined that a NF is not able to safely meet the needs of a member (e.g., due to dangerous behaviors) or because the member no longer meets the NF level of care requirement, the MCO will continue to pay the facility until the member is transitioned to a safe and alternate placement.

When a member who resides in an out-of-network NF is hospitalized, the MCO will allow the member to return to the out-of-network NF upon discharge from the hospital when all of the following criteria are met:

- Returning to the NF meets the member's preferences and level of care needs.

- There is a bed available at the member's prior NF.
- The NF will accept the member at Medicaid rates (or negotiated rate between the MCO and the facility. The negotiated rate must be in accordance with the required payment terms for NFs as described in this contract).

In the event of a NF closure, or as necessary to protect the health and safety of residents, the MCO will arrange for the safe and orderly transfer of all members and their personal effects to another facility. In addition to any notices provided by the facility, the MCO will provide timely written notice inclusive of the required elements in CFR §483.75 (r) and work cooperatively with the Department of Social Services, including the local Departments of Social Services, the long-term care ombudsman, and other state agencies in arranging the safe relocation of residents. The MCO's care coordinator will coordinate the relocation plan and act as a resource manager to other agencies and as a central point of contact for member relocations.

Members Who Transition Between MCOs, contract section 5.14.4

The MCO will transfer SA, HRA, ICP, and other pertinent information necessary to assure continuity of care to another MCO, to DMAS, or its designated entity for members who transfer to another MCO or back to FFS. The information shall be provided within three business days from receipt of the notice of disenrollment to the MCO in the Medical Transition Report (MTR) method and format specified by the Department. The MCO will work with the other MCO in facilitating a seamless transition for the member.

Medallion 4.0 MCO Accountability:

Continuity of Care Provisions, RFP section 4.4.4

To ensure there is no interruption of any covered services for enrollees, policies and procedures will be developed by the MCO to ensure continuity of care for all enrollees that include the information below. During the time period set below, the MCO will maintain the enrollee's current providers at the Medicaid FFS rate and honor SAs issued prior to enrollment for the specified time period.

An enrollee will be allowed to maintain his or her current providers (including out-of-network providers) during the continuity of care period, or where services are authorized, for the duration of the SA or through the end of the continuity of care period, whichever comes first. During the continuity of care period, the MCO may change an enrollee's existing provider only in the following circumstances: (1) the enrollee requests a change, (2) the provider chooses to discontinue providing services to an enrollee as currently allowed by Medicaid, (3) the MCO or DMAS identifies provider performance and/or quality of care issues that affect an enrollee's health or welfare, or (4) the provider is excluded under state or federal exclusion requirements.

During the continuity of care period, reasonable efforts will be made to contact out-of-network providers who are providing services to enrollees during the initial continuity of care period, and provide them with information on becoming credentialed, in-network providers. If the provider does not join the network, or the enrollee does not select a new in-network provider by the end of the continuity of care period, the MCO will choose one for the enrollee. The MCO must offer single-case agreements to providers who are not willing to enroll in the MCO's provider network and under special circumstances that will be outlined in the managed care contracts.

SAs issued by the Department or its MCOs will be honored as provided through DMAS transition reports and DMAS's contracted entities for the duration of the SA or the continuity of care period, whichever comes first.

If, as a result of the HRA development, the MCO proposes modifications to the enrollee's SAs, the MCO will provide written notification to the enrollee and an opportunity for the enrollee to appeal the proposed modifications.

The MCO will transfer SA and other pertinent information, as defined by contract, necessary to assure continuity of care to another MCO, to DMAS, or its designated entity for enrollees who transfer to another health plan or back to FFS. The information will be provided within three business days from receipt of the notice of disenrollment to the MCO in the method and format specified by DMAS. The MCO will work with the Department to develop and implement an automated process for sharing and honoring SAs for members who transition between the FFS, CCC Plus, Medallion 4.0, or other DMAS programs and from one health plan to another. The MCO will share the necessary data in a Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant format as directed by DMAS.

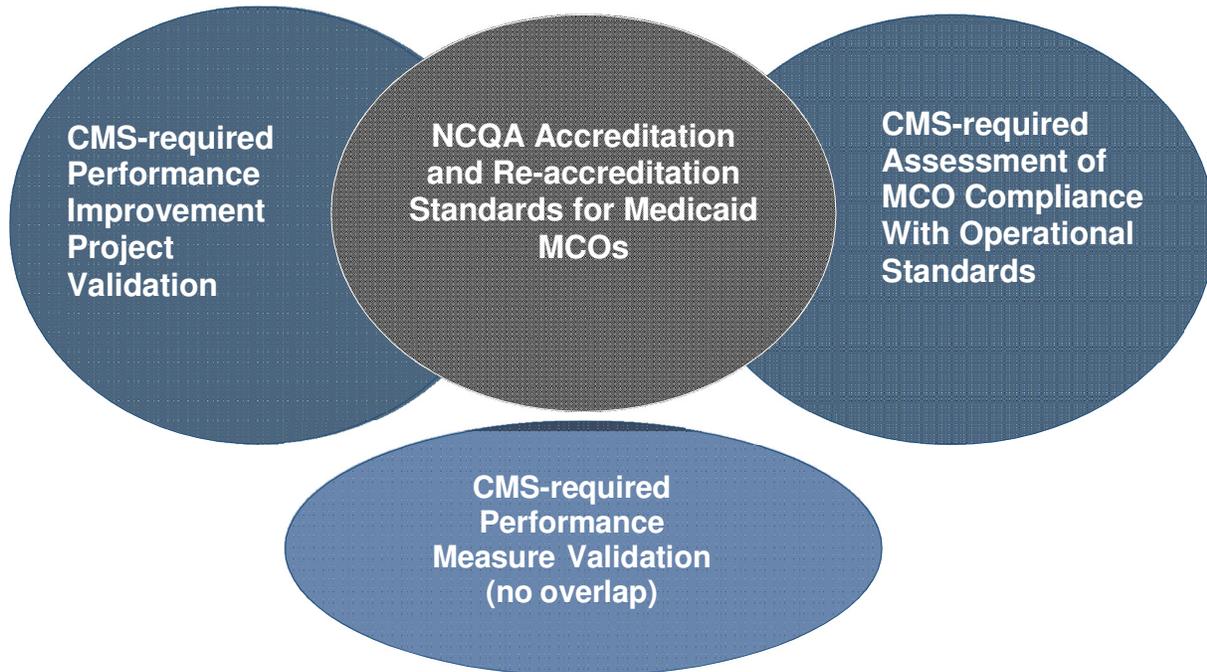
Avoiding Duplication of EQR Activities

Using NCQA Accreditation Results §438.360 (a) (b) (c)

DMAS requires all of the contracting MCOs to be accredited by the National Committee for Quality Assurance (NCQA). As such, DMAS deems certain external quality review (EQR)-related activities (On-Site Reviews [Protocol 1] standards) that crosswalk to CMS requirements.

There is some overlap between NCQA's quality standards the MCOs must meet to maintain accreditation and the three CMS-mandated quality activities performed by DMAS's contracted external quality review organization (EQRO). Figure 3 depicts a snapshot of federally required EQR activities and the potential for duplication for each with NCQA accreditation standards.

When these overlaps are clear, DMAS deems most of the duplicative CMS-EQR requirements as being met (hereafter referred to as "deeming") as long as the MCO meets the accreditation standards. The criteria for deeming is supported in 42 CFR §438.360 (non-duplication of mandatory activities). Although the performance measure validation activity seems duplicative of annual HEDIS audits experienced by the MCOs, it may not be deemed, according to CMS.

Figure 3—CMS-Mandated External Quality Review Activities Partially Overlap With NCQA Accreditation

Crosswalking CMS EQR Standards and NCQA Accreditation Standards §430.360 (a) (2)

NCQA annually publishes an updated crosswalk between the CMS quality standards and NCQA accreditation standards. While CMS does not formally endorse the crosswalk, CMS participates in the review process before the crosswalk is published. Therefore, DMAS views the crosswalk as a guide, not a determination of deeming.

DMAS and the EQRO conduct an in-depth review of the crosswalk and use it as a guide for ascertaining which standards can be deemed as being met during the comprehensive reviews required by federal regulations. If there seems to be any ambiguity in the crosswalk or any standards that, in the opinion of the EQRO and DMAS, should not be deemed, the standards in question are included in the comprehensive review. The commonality between those elements deemed as “not met” and needing to be reviewed by the EQRO are those that the CFR requires (and NCQA does not); and those for which the CFR enables states to define the policies and criteria.

The most recent MCO comprehensive review was conducted for the Medallion 3.0 program in spring 2017. See Appendix A for the State Fiscal Year 2017 Deeming Review Executive Summary. A similar process is used to identify duplicative elements within PIP validations. DMAS selects two HEDIS measures to fulfill the annual PIP requirements.

§438.360 (b) *External Quality Review Report*

When DMAS uses information from a Medicare or private accreditation review in accordance with paragraph (a) of this section, it ensures that all such information is furnished to the EQRO for analysis and inclusion in the report described in §438.364(a).

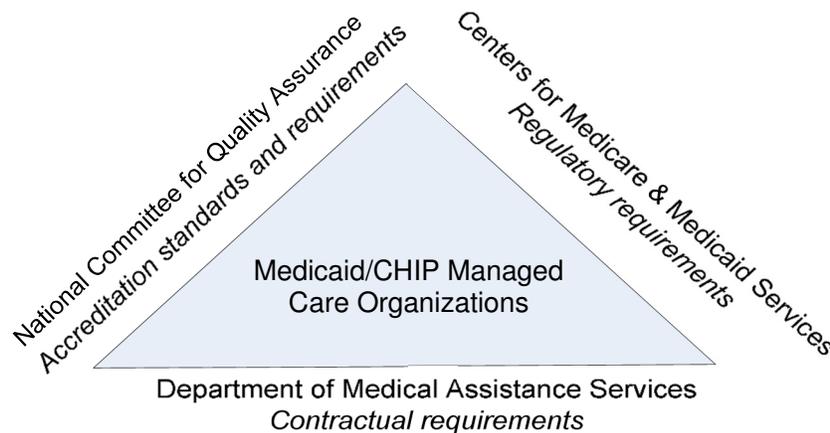
Driving Improvement and Monitoring Progress

DMAS developed and uses a quality framework that leverages existing sets of standards and requirements for providing and continuously improving the quality of its managed care delivery system.

There are three fundamental sets of requirements and standards from CMS, DMAS, and NCQA that converge for a bold quality framework for Virginia's Medicaid/CHIP managed care delivery system. Some of the requirements and standards overlap, resulting in resource efficiencies for assessing quality; however, each set provides for a different and important perspective on the quality of managed care.

The requirements and standards serve as the basis for this edition of the Quality Strategy and are depicted in the framework in Figure 4.

Figure 4—Medicaid/CHIP Managed Care Quality Framework



The contracts between DMAS and each MCO provide for the following legal order of precedence:

- 1) Federal Regulations
- 2) Virginia State Plan
- 3) Medicaid and CHIP Waivers
- 4) Medicaid and CHIP State Regulations
- 5) DMAS Medicaid and CHIP contracts with MCOs
 - It should be noted that the DMAS Medicaid and CHIP contracts with MCOs explicitly state that the MCO must be NCQA accredited.

Should there be any conflicting requirements or standards between CMS, DMAS, or NCQA, this legal order of precedence is followed.

Developing Goals and Objectives for Continuous Quality Improvement

One of the overarching aspirations of DMAS for this edition of the Quality Strategy is to begin to integrate the quality management program across DMAS by applying the same quality standards and adopting a

common subset of quality metrics to drive quality improvement in the Medallion 4.0 and CCC Plus programs. These aligned performance measures are detailed in Table 4. A second aspiration is to increase synergy between DMAS and local, state, and national health care quality improvement stakeholders by aligning initiatives and leveraging their work. As such, DMAS aligned its Quality Strategy Goals and Objectives with those of the stakeholders listed in Table 3.

One approach to integrating quality across DMAS and leveraging the work of local stakeholders involves convening quarterly collaboratives amongst health plans and the State. Collaborative topics include discussions of best practices, review of results of performance measures, and training for PIPs.

Alignment and Collaboration

Table 3—Alignment of DMAS Quality Strategy With National, State, and Local Healthcare Stakeholders

Stakeholder	Health Care Quality Goals and Initiatives
<p>U.S. Department of Health and Human Services (HHS)¹¹</p>	<p>The <i>National Quality Strategy</i> (NQS) was first published in March 2011 as the National Strategy for Quality Improvement in Health Care, and is led by the Agency for Healthcare Research and Quality (AHRQ) on behalf of the U.S. Department of Health and Human Services (HHS).</p> <p>The NQS was developed through a transparent and collaborative process with input from a range of stakeholders. More than 300 groups, organizations, and individuals, representing all sectors of the health care industry and the general public, provided comments. Based on this input, the NQS established a set of three overarching aims that build on the Institute for Healthcare Improvement's Triple Aim, supported by six priorities that address the most common health concerns that Americans face. Stakeholders can use the nine levers to align their core business or organizational functions with the NQS to drive improvement on the aims and priorities.</p>
<p>National Prevention Council¹²</p>	<p>The <i>National Prevention Strategy</i> will move us from a system of sick care to one based on wellness and prevention. It builds on the state-of-the-art clinical services we have in this country and the remarkable progress that has been made toward understanding how to improve the health of individuals, families, and communities through prevention.</p> <p>The National Prevention Strategy encourages partnerships among federal, state, tribal, local, and territorial governments; business, industry, and other private sector partners; philanthropic organizations; community and faith-based organizations; and everyday Americans to improve health through prevention. For the first time in the history of our nation, we have developed a cross-sector, integrated national strategy that identifies priorities for improving the health of Americans. Through these partnerships, the National Prevention Strategy will improve America's health by helping to create healthy and safe communities, expand clinical and community-based preventive services, empower people to make healthy choices, and eliminate health disparities.</p> <p>We know that preventing disease before it starts is critical to helping people live longer, healthier lives and keeping health care costs down.</p>

Stakeholder	Health Care Quality Goals and Initiatives
<p>Virginia Department of Health ¹³</p> <p>and</p> <p>Virginia Center for Health Innovation (VCHI)¹⁴</p>	<ul style="list-style-type: none"> <p><i>Virginia’s 2016 State Innovation Model Health Improvement Plan</i></p> <p>Better value for a healthier Commonwealth is the principle that drives the recent work of both the Virginia Center for Health Innovation (VCHI) and Virginia Department of Health, leading Virginia’s State Innovation Model (SIM) design. SIM, a CMS initiative, provides financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery reforms. Through this program, VCHI is working to create opportunities to improve the value of health care in Virginia, where value is defined as the best possible health outcomes delivered as efficiently as possible.</p> <p>As the only non-profit, non-state agency in the country to lead the development of a SIM design, VCHI is proving public-private collaboration works. VCHI has brought together hundreds of stakeholders from all regions and constituencies to develop solutions to come of our most complex health care challenges.</p> <p><i>Virginia’s Plan for Well-Being (2016–2020)</i>¹⁵</p> <p><i>Virginia’s Plan for Well-Being</i> is a companion plan to Virginia’s <i>2016 State Innovation Model Health Improvement Plan</i>, which calls for Accountable Care Communities in Virginia to achieve the triple aim in health care: improving health care quality; improving the health of populations; and reducing the per capita cost of health care. <i>The Virginia Center for Health Innovation</i> and the <i>Virginia Department of Health</i> are committed to tracking the progress of Virginia’s health improvement and to annually report on specific measures identified in the two plans. Using population health data to evaluate our progress can help Virginians assess whether our systems and strategies are effective and can guide us to change course where needed.</p>
<p>Virginia Department of Health Office of Health Equity (OHE)¹⁶</p>	<p>The Office of Health Equity’s mission is to identify health inequities and their root causes and promote equitable opportunities to be healthy. The office develops programs and partnerships to empower racial and ethnic minority communities to promote awareness of health inequities. The goal of the OHE is to permanently change the conditions that produce differential health outcomes that will, over time, have a greater effect than traditional interventions.</p> <p>Within OHE, the Division of Multicultural Health and Community Engagement works with stakeholders to identify approaches to eliminate health inequities through a focus on social determinants of health as a key strategy to eliminate health inequities that exist by socioeconomic status, race/ethnicity, geography, gender, immigrant status, and other social classifications. There are five U.S. Census-recognized racial and ethnic minority populations in Virginia:</p> <ol style="list-style-type: none"> 1) African-American/Black 2) Hispanic/Latino 3) Asian-American 4) Native Hawaiian or Other Pacific Islander 5) American Indian and Alaskan Native 6) People of two or more races

Stakeholder	Health Care Quality Goals and Initiatives
<p>Virginia Health Reform Initiative¹⁷</p>	<p>Every Virginian needs access to appropriate and affordable health care. The challenge the Commonwealth faces is how to provide that access in an economically responsible manner. The purpose of the Virginia Health Reform Initiative is to go beyond federal health reform and recommend other innovative health care solutions that meet the needs of Virginia’s citizens and government.</p> <p>The Virginia Health Reform Initiative will ensure that meaningful reform is achieved throughout the Commonwealth. There is a desire to see that the health care delivery system as a whole is positively impacted as a result of the work accomplished through the initiative. From insurance and payment reforms to how care is delivered, the initiative will work with stakeholders to reduce costs and improve quality.</p> <p>The initiative will seek to build on what is already successful in Virginia and will remodel or reorganize practices that do not achieve optimal results. It is recognized that this effort must leverage the strengths of competent, effective government with the experience and knowledge of the private sector. Together, great things will be achieved throughout Virginia. The initiative will implement reform in a way that is unique enough to meet Virginia's specific needs, cost effective, and beneficial to all involved.</p>
<p>The Virginia Health Care Foundation¹⁸</p>	<p>A public/private partnership, VHCF helps uninsured Virginians and those who live in underserved communities receive medical, dental, and mental health care. VHCF support helps free clinics, community health centers, and others to expand both the types of care offered and the number of patients cared for each year. In addition to grants, VHCF programs help make prescription medications available to those who cannot afford them.</p> <p>VHCF has helped to underwrite and encourage the approach of integrating delivery of behavioral health services and medical care to free clinics and health centers through a variety of grants and mental health roundtables.</p> <p>VHCF’s Children’s Health Insurance Initiative works both in local communities and at the State level to increase enrollment of eligible children and pregnant women in Virginia’s state-sponsored health insurance programs, FAMIS and FAMIS Plus. FAMIS provides coverage for doctor and hospital visits, vaccinations and prescription medications, dental, vision and mental health care, and more. A family of four with a monthly income up to \$4,203 could qualify for coverage for their children.</p>
<p>Robert Wood Johnson Foundation (RWJF)/University of Colorado— Behavioral Health Transformation</p>	<p>The Commonwealth was selected as one of only three states to receive research support and policy guidance for the transformation of the State’s behavioral health delivery system, through a grant from the Robert Wood Johnson Foundation. Experts from the University of Colorado’s Farley Center for Health Policy are combining data from several state agencies, including Medicaid, to develop a comprehensive picture of how Virginians’ behavioral health needs are being met. The team of experts will also provide recommendations for future opportunities to state government and agency leadership. The Commonwealth has the option of extending services into an implementation phase, at a cost to the State, and has not yet elected to do so.</p>

Stakeholder	Health Care Quality Goals and Initiatives
Children’s Health Insurance Program Advisory Committee	<p>The Children’s Health Insurance Program Advisory Committee (CHIPAC) was established by the Virginia Legislature and is maintained by the Department of Medical Assistance Services. The purpose of the committee is to assess the policies, operations, and outreach efforts for Family Access to Medical Insurance Security (FAMIS) and FAMIS Plus (children’s Medicaid) and to evaluate enrollment, utilization of services, and health outcomes of children eligible for such programs.</p> <p>CHIPAC meets quarterly and consists of a maximum of 20 members. These organizations are mandated by the Code of Virginia to have a member serve on CHIPAC: The Joint Commission on Health Care; the Department of Social Services; the Department of Health; the Department of Education; the Department of Mental Health, Mental Retardation and Substance Abuse Services; and the Virginia Health Care Foundation. Additional, nonmandated members are from various provider associations, children’s advocacy groups, or individuals with significant knowledge and interest in children’s health insurance issues.</p>
March of Dimes Committee	<p>The March of Dimes Committee is a national voluntary health agency whose volunteers and staff work to improve the health of infants and children by preventing birth defects, premature birth, and infant mortality by funding programs of research, community services, education, and advocacy. The goal is to reduce preterm birth rates from 9.2 percent to a rate of 8.1 percent by 2020.</p>
LARC (Long-Acting Reversible Contraceptives) Stakeholder Workgroup	<p>LARC refers to methods of birth control, including intrauterine devices (IUDs) and implants, which prevent pregnancy for three to 12 years. LARCs improve health by reducing unintended pregnancy and increasing birth spacing. The workgroup includes DMAS representatives and holds quarterly meetings.</p>
CARE (Coordinating Access, Responding Effectively) Workgroup	<p>This is an interagency effort to identify a coordinated, state-level response to maternal substance use. The workgroup includes the Virginia Department of Behavioral Health & Developmental Services (DBHDS) and DMAS, and is tasked with developing an ongoing workplan for the Commonwealth to enhance efforts to serve substance-using pregnant and parenting women and their families.</p>

Consistent with the goals of those stakeholders, DMAS established the quality goals and objectives displayed in Table 4 to improve the health and wellness of Virginia’s Medicaid and CHIP members.

DMAS’s goals are based on four aims, and the aims are based on three foundational guiding principles for meeting the mission and vision described in the Introduction Section of this document. The three guiding principles are listed below:

- 1) Superior Care
- 2) Cost Effective
- 3) Continuous Improvement

The four publicly promoted aims are as follows:

- 1) Build a Wellness Focused, Integrated System of Care
- 2) Focus on Screening and Prevention
- 3) Achieve Healthier Pregnancies and Healthier Births
- 4) Improve Wellbeing Across the Lifespan

To accomplish the goals, specific objectives (i.e., measurements) and performance targets are used to guide implementation of interventions. This approach provides for data-driven decision making to drive interventions, inform priority setting, and facilitate efficient and effective deployment of resources. Table 4 shows the goals, objectives, interventions, and quality indicator for a set of crosscutting measures (that apply to members in Medallion 4.0 as well as CCC Plus) related to each of DMAS’s four aims

Establishing Quality Metrics and Performance Targets Used for Measuring Performance and Improvement

DMAS has identified clinical quality, access, and utilization measures for the CCC Plus and Medallion 4.0 programs using the nationally recognized measure sets listed in Table 4. DMAS includes a subset of HEDIS measures to track and trend MCO performance and to establish benchmarks for improving the health of Medicaid and CHIP populations served through the managed care delivery system. The measures listed in the DMAS Quality Dashboard are prioritized for continuous improvement and selected based on the needs of the populations served and the favorable health outcomes that result when relevant clinical guidelines are adhered to by each MCO’s provider network. Additionally, when selecting measures for the specific needs of the populations (e.g., CCC Plus versus Medallion 4.0), DMAS takes into consideration the availability and reliability of the data that are used to calculate the measures.

Table 4—DMAS Quality Dashboard

DMAS Quality Dashboard
August 28, 2017

Health Aims	Goals	Examples of Measures
Build a Wellness Focused, Integrated System of Care	Strengthen access to primary care network (4.1)	HEDIS: Adults' Access to Primary Care (Preventative/Ambulatory Health Services) HEDIS: Children and Adolescents' Access to Primary Care
	Decrease inappropriate utilization and total cost of care	All-Cause PQI Admission Rate
		CMS/NQF #1768: Plan All-Cause Readmissions
		HEDIS: Ambulatory Care - Emergency Department Visits
	Emphasize member experience of care	Per Capita Healthcare Expenditures (future measure)
		CAHPS/HEDIS/NQF #0006: Member Rating of Health Plan
	Integration of behavioral, oral and physical health (4.1)	CMS/HEDIS/NQF #0004: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (2 rates)
		CMS/NQF #1664: SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge
		HEDIS/NQF #0576: Follow Up After Hospitalization for Mental Illness, 7-day Follow Up
		CMS/NQF #2605: Follow Up After Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence
		CMS: Transition of Members Between SUD LOCs, hospitals, NF and the Community
		Use of High-risk Medications in the Elderly
		NCQA: Use of Multiple Concurrent Antipsychotics in Children and Adolescents
		HEDIS: Follow-up Care for Children Prescribed ADHD Medication - Initiation and Continuation/Maintenance Phases
		HEDIS: Antidepressant Medication Management - Effective Acute Phase Treatment, Effective Continuation Phase Treatment
PQA: Use of Opioids at High Dosage in Persons Without Cancer		
Encourage appropriate management of prescription medications	PQA: Use of Opioids from Multiple Providers in Persons Without Cancer	
	PQA: Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer	
	HEDIS/NQF #2372: Breast Cancer Screening	
	NQF #0034: Colorectal Screening	
	HEDIS/NQF #0032: Cervical Cancer Screening	
Focus on Screening and Prevention	Cancers are prevented or diagnosed at the earliest stage possible (3.4)	AMA-PCPI/NQF #0027: Tobacco Use - Screening and Cessation
	Prevention of nicotine dependency (3.2)	HEDIS: Childhood Immunization Status (Combo 10)
	Virginians protected against vaccine-preventable diseases (3.3)	HEDIS: Immunizations for Adolescents
		HEDIS: Pneumococcal Vaccination Status for Older Adults

DMAS Quality Dashboard
August 28, 2017

Health Aims	Goals	Examples of Measures
Focus on Screening and Prevention	Virginians protected against vaccine-preventable diseases (3.3)	HEDIS: Flu Vaccinations
	Support consistency of recommended pediatric screenings	CMS/HEDIS: Annual Preventative Dental Visits
		HEDIS: Well-Child Visits, 1st 15 Months of Life
		HEDIS: Well-Child Visits in 3rd, 4th, 5th, 6th Years of Life
		HEDIS: Adolescent Well-Care Visits (12-21 Years)
Achieve Healthier Pregnancies and Healthier Births	Virginians plan their pregnancies (2.1)	OHSU: Developmental Screening in the First 3 Years of Life
	Improved pre-term birth rate	NQF 2902/OPA: Contraceptive Care - Postpartum Women Ages 15-44
		HEDIS: Postpartum Care Visit
		Early Elective Deliveries Rate
		HEDIS: Timeliness of Prenatal Care
Maximize Wellbeing Across the Lifespan	Effective management of chronic respiratory disease	HEDIS: Frequency of Ongoing Prenatal Care
	Comprehensive management of diabetes	CMS/CDC/PQI: Percent of Live Births <2,500 Grams
		Effective management of cardiovascular disease
	Ensure quality of life for members with intensive healthcare needs	PQI 15: Asthma in Younger Adults Admission Rate
		CMS/PQI 05/NQF #0275: COPD and Asthma in Older Adults Admission Rate (2 measures)
		HEDIS: Comprehensive Diabetes Care
		PQI 01/NQF #0272: PQI Diabetes Short-term Complication Admission Rate
		HEDIS/NQF #0018: Controlling High Blood Pressure
		JLARC: Nursing Facility Diversion - # and % of New Members Meeting Nursing Facility Level of Care Criteria Who Opt for Home & Community Based Services (HCBS) Over Institutional Placement
		Quality of Life and Member Satisfaction Survey CMS-Specific Assessments and Reassessments
	Plan of Care and POC Revisions	
Provide support for End of Life	Documentation of Care Goals	
	% Enrollees with Advanced Directives	

Usually, DMAS selects the same measures for a number of years to enable statistically sound trending of data. Trending provides DMAS and the MCOs to further realize the impact of ongoing quality improvement initiatives, rather than basing the effectiveness on just one year’s worth of data.

DMAS and the MCOs recognize that effective quality improvement must be methodical, ongoing, and measurable. Beginning with fiscal year 2012 on each of the DMAS-selected HEDIS measures, DMAS has stretched its previous goal for MCOs to that of reaching the 75th percentile in NCQA’s Quality Compass.

While it is not realistic to expect all Virginia MCOs to reach the 75th percentile for all of the priority measures, setting this stretched goal is instrumental in achieving the goals and objectives of managed care quality improvement for Virginia. The EQR annual technical reports include the participating Virginia MCO HEDIS scores for the reporting year. Overall, there has been a steady improvement in HEDIS rates for the MCOs. However, most, but not all of the 2016 Virginia averages for Medicaid/CHIP managed care were below the 75th percentile, reinforcing the opportunity for continued improvement.

Establishing Performance Targets

DMAS uses absolute performance targets in addition to using relative percentile rankings. DMAS uses a 75th percentile target-setting methodology based on NCQA’s Quality Compass report showing comparative

and descriptive performance information on hundreds of Commercial, Medicaid and Medicare health plan submissions as well as national, regional, and state benchmarks. The online Quality Compass reports provide up to three years of performance trending of HEDIS and CAHPS^{®20} measures for publicly reporting plans.

Use of National Performance Measures

DMAS uses HEDIS data whenever possible to measure the MCOs' performance with specific indices of quality, timeliness, and access to care. DMAS's EQRO conducts NCQA HEDIS Compliance Audits^{™,21} of the MCOs annually and reports the HEDIS results to DMAS. As part of the EQR annual technical report, the EQRO performs a comparison of the rates between the MCOs and also compares the individual health plan and aggregate rates with available Medicaid percentile data published by NCQA.

Criteria for Selecting Access Measures

Appropriate measures for services and beneficiary groups enrolled in each managed care program

DMAS focuses on selecting a mix of measures related to access to acute, primary, and specialty services. These include access metrics specific to mental health and substance use disorder services for behavioral health organizations, and metrics related to long-term services and supports (LTSS) for managed long-term services and supports (MLTSS) programs. Since the managed care programs cover diverse populations, such as nondisabled children, pregnant women, disabled adults, and seniors, access metrics address each of these groups, as illustrated by the metrics in Table 4.

Ability to stratify data to identify “hot spots”

To identify the MCOs, regions within the State, and population groups with more acute problems, the data DMAS uses to construct the measures are granular enough to sort by plan, region, or county within the State, and by sociodemographic characteristics, such as race or ethnicity.

Benchmarking

DMAS uses metrics that are included in the NCQA Quality Compass Report to allow comparisons of enrollee outcomes against national benchmarks. These are included in Table 4.

Data availability

DMAS selects metrics that states and plans can construct with existing data to reduce data collection burden and makes it possible to monitor performance regularly, using sources such as HEDIS and CAHPS. DMAS plans to institute additional metrics as new data sets or sources become available—for example, via health information exchanges and from electronic health records.

Reporting Performance Data to the State §438.330 (c) (2) (i–ii)

CCC Plus Contract

Where DMAS determines that the MCO has failed to comply with the Department’s data exchange requirements or is noncompliant with data quality benchmarks, DMAS may impose the sanctions set out below effective January 1, 2018. The process for the Department’s imposition of sanctions shall comply with the requirements of 42 CFR §380, Subpart I.

The Department will develop for the MCO a Data Quality Scorecard, which will be described in supporting documentation. The Data Quality Scorecard may include up to 40 data quality performance metrics, and performance by the MCO on the scorecard will be communicated monthly by the Department to the MCO. If a new data quality metric is to be added to the Data Quality Scorecard, the MCO will have 90 calendar days before data quality withholds may occur based on the MCO’s performance on that metric.

Where DMAS determines that the MCO has failed to submit required data or to meet a data quality benchmark on any metric of the Data Quality Scorecard, the Department will send a notice of noncompliance. The Department reserves the right to apply penalties for noncompliance.

A Notice of Non-Compliance by the Department to the MCO will include:

- 1) A description of the data quality issue and the MCO’s performance on any metrics that triggered the noncompliance notice.
- 2) The action that will be taken by the MCO in order to cure the performance failure.
- 3) Financial withhold or penalties as a result of noncompliance.

The Department may require the MCO to replace any noncompliant data with compliant data at no cost to the Department. Any cost incurred by the Department to reprocess replacement data will be passed through in its entirety to the MCO. Costs for replacing noncompliant data with replacement data will be based on any charges from the Department to a third party as well as Department staff time.

Medallion 4.0 RFP

The following requirements apply to all submissions, including encounter data. For each data submission, the MCO will:

- 1) Collect and maintain 100 percent of the data required by the Department.
- 2) Submit complete, timely, reasonable, and accurate data as defined by the Department in its supporting documentation including, but not limited to, the Data Quality Scorecard, which will include:
 - a) Metrics that measure completeness, timeliness, and accuracy of the data.
 - b) Benchmarks that describe whether the MCO’s performance is compliant with the Department’s requirements.
 - c) A description of how each measure is calculated by the Department.
- 3) Use standard formats, include required data elements, and meet other submission requirements as detailed in its supporting documentation.
- 4) Ensure that MCO data can be individually linked to Department data at the record level (e.g., MCO data on members can be linked to the Department’s unique member identifier).
- 5) Provide any reports on required data as requested by the Department.

Data Strategy for the Near Future

Virginia Medicaid’s strategy for clinical data comprises three areas: Automation, Connection, and Information.

Automation

First, Virginia plans to build connections to as many sources of relevant clinical data as possible—the “Automation.” The collection of Virginia Medicaid’s clinical data begins with laboratory interfaces from the Magellan Pharmacy Benefit Management System as well as admission, discharge, and transfer (ADT) transactions from the Emergency Department Care Coordination (EDCC) project (currently in its project execution phase) that will provide routine data feeds to DMAS. As the integration efforts begin to complete, adjustments to provider contracts may be considered.

The next stage involves a pilot to establish DMAS as a node on the National Health Information Network (NHIE) in conjunction with ConnectVirginia, Virginia’s state-based HIE. As a “node” on the NHIE, DMAS will be able to obtain clinical records from providers connected via electronic medical record (EMR) systems (in Virginia or neighboring states) for its Medicaid/CHIP program members. This pilot is contingent on DMAS developing use cases allowed under the expanded Data Use and Reciprocal Support Agreement (DURSA) between the NHIE and ConnectVirginia. A variety of federal funding is available for HIT integration projects although there are significant constraints in use of the funds. To better optimize federal funding assistance and guide forward direction, an HIT strategic plan may be developed in conjunction with stakeholder groups in the next biennium. Currently, the ED care coordination project is funded and moving forward as is the implementation/onboarding to the National Health Information Network (NHIN)/HIE, which is currently expected to be operational July 2018, assuming data sharing agreements permit the exchange.

Connection

The clinical records will be stored in an enterprise data warehouse system (EDWS) for statistical analysis supporting clinical use cases—the “Connection.” DMAS is in the final stage of the RFP process, and the confidentiality of the process prohibits naming a definitive timeline for announcing a vendor. However, the vendor selected will provide components such as Extract-Transform-Load (ETL) services, business intelligence and data services, master data management, data marts, storage services, data mining, statistical analytics, and predictive analytics to provide enhanced business functionalities.

The EDWS infrastructure will also be able to:

- Integrate disparate data sources (both internal and external) and be the central repository of data for DMAS.
- Standardize data according to Agency standards set by the data governance program.
- Engage in the secure and automated exchange of data.
- Support the integration of clinical and administrative data.

It is anticipated that one year from awarding of the contract to the vendor, a substantial amount of data will be loaded, cataloged, and profiled in the data warehouse. Additionally, capabilities for ongoing receipt of data from external sources (e.g., encounters from managed care organizations) will be tested in the EDWS.

As the EDWS is populated with clinical data, along with data from other sources, many analyses that before were impractical (either due to insufficient or incomplete data) will become possible with the storage, quality validation, and standardization offered by a data warehouse. These analyses transform the raw data into “information” to inform strategies and operations. Such analyses include, but are not limited to,

- Risk stratification where members can be scored based on health risks compared to an overall group of individuals.
- Timely identification of potentially preventable events (PPEs) as a way to hone in on unnecessary services or poor quality of care.
- Dashboards that trend health care quality metrics important to care management.
- Automated controls for prevention and fraud detection.

The increased insight into Virginia Medicaid’s population will provide DMAS with the ability to align strategic and operational priorities with the ultimate goal of improving clinical quality and population health outcomes. Functionally, DMAS plans to use these transformative data to better focus efforts on:

- Driving innovations in payments for value.
- Improving efficiencies in Medicaid operations and identifying potential cost savings.
- Identifying common gaps in care to inform quality improvement projects.
- Holding MCOs accountable for the care they coordinate and outcomes they achieve for Medicaid enrollees.
- Targeted work to reduce disparities, and identify and manage super utilizers and other population-specific health needs.
- Informing the Governor’s office, Health and Human Resources secretary, and General Assembly on data-driven priorities with future policy implications.
- Evaluation of programs on measures of cost, quality, access, coverage, etc.
- Increased predictive modeling capabilities, for example, of potential impacts of policy changes.

Information

New data capabilities will also provide further support to several of DMAS’s projects, both in the ability to evaluate the effectiveness of such programs and to garner support for future investment in DMAS initiatives by the Governor and General Assembly. Several current, innovative projects in particular will benefit from the ability to use better data to align interagency resources for the health of Medicaid enrollees and the benefit of the Commonwealth, and may also provide the foundations and relationships for future quality efforts. These include, but are not limited to:

- ED Care Coordination
Also mentioned above, the EDCC Program aims to improve individuals’ health by providing information which assists providers in proactively redirecting their care and connecting them to more appropriate primary care settings. Five percent of patients account for nearly 25 percent of all ED visits in the United States. These high utilizers of ED services typically do not receive the right care, with the right provider, at the right time—or at the right price. High utilizers often present to the ED with low-acuity, chronic health concerns that are less appropriately addressed in the ED, which is designed to care for acute, episodic and emergent health conditions.

Establishing comprehensive primary care relationships with these individuals will reduce ED visits and decrease hospital charges, while providing the right care in the best setting for the patient. Ultimately, a patient's relationship with his or her community-based, primary care providers will be supported and strengthened, leading to improved adherence to treatment recommendations and continuity of care. Reinforcement of the proper use of the health care delivery system teaches and enables participants to have their needs met by making informed decisions and directly accessing appropriate care.

The 2017 General Assembly established the Emergency Department Care Coordination program in the Department of Health to provide a single, statewide technology solution that connects all hospital emergency departments in the Commonwealth to facilitate real-time communication and collaboration between physicians, other health care providers, and other clinical and care management personnel for patients receiving services in hospital emergency departments, for the purpose of improving the quality of patient care services (Code of Virginia §32.1-372). Real-time patient visit information from electronic health records will be integrated with the Prescription Monitoring Program and the Advanced Health Directory. This sharing of information will allow facilities, providers, and MCOs to identify patient-specific risks, create and share care coordination plans and other care recommendations, and access other clinically beneficial information related to patients receiving services in hospital EDs in the Commonwealth.

- **Addiction and Recovery Treatment Services (ARTS)**

In 2016, an estimated 1,133 Virginians died of suspected opioid overdoses. Medicaid members are prescribed opioids at twice the rate of non-Medicaid members and are at three-to-six times the risk of opioid overdose. The Medicaid ARTS benefit was funded in the 2016 Appropriations Act with bipartisan support from the Governor and General Assembly to expand access to life-saving addiction treatment by transforming the delivery system for Medicaid members with substance use disorders (SUD).

DMAS's ARTS program launched on April 1, 2017, and is already generating great interest as a national model of a comprehensive, evidence-based delivery system transformation by Medicaid to respond to the addiction crisis in the United States. Based on the industry standard's American Society of Addiction Medicine (ASAM) levels of care, the ARTS benefit will provide the full continuum of evidence-based addiction treatment to any of the 1.1 million Medicaid and FAMIS members who need treatment. In addition, the new program "carves in" the community-based addiction treatment services into MCOs to promote full integration of physical health, traditional mental health, and addiction treatment services.

The ARTS benefit allowed the Commonwealth to be approved by CMS for an 1115 waiver that will significantly expand residential SUD treatment capacity. As part of the waiver, CMS requires an evaluation of the effectiveness of the services delivered in terms of clinician ARTS training and service provision as well as Medicaid member health outcomes, health care costs, and service utilization. To that end, a team of researchers from the Virginia Commonwealth University School of Medicine is conducting a robust evaluation of the new ARTS benefit and demonstration.

To further support the transformational integration of behavioral and physical health, the Commonwealth of Virginia was selected by the Robert Wood Johnson Foundation as one of three states to receive programmatic support by a team of policy and research experts at the University of Colorado Eugene S. Farley, Jr. Health Policy Center.

- **Perinatal Quality Collaborative**

Funding for the Perinatal Quality Collaborative was provided for the Virginia Department of Health to establish and administer a learning collaborative to improve pregnancy outcomes for women and newborns by advancing evidence-based clinical practices and processes through continuous quality improvement, with an initial focus on pregnant women with substance use disorder and infants impacted by neonatal abstinence syndrome. Since 77 percent of infants born with neonatal abstinence syndrome (NAS) were covered by Medicaid in 2015, DMAS's participation is vital, both because of the

ability to provide data to inform improvement efforts, and because of the Agency’s ability to draw down matching federal Medicaid administrative funds to support the work.

The funding includes support for several administrative positions to run operations, and also memberships/connections for a limited number of pilot sites to the Vermont Oxford Network. Vermont Oxford Network data are collected from neonatal ICUs across the country and are reported in accordance with national standards. The network provides resources for states and members on many topics relevant to perinatal care, including NAS.

Performance Improvement Projects (PIPs) to Improve Access, Quality, or Timeliness of Care §438.330 (d) (1-3)

DMAS MCO contracts require MCOs to measure and report on performance to assess the quality and appropriateness of care and services provided to members. Validation of performance improvement projects (PIPs) is one of three mandatory external quality review (EQR) activities that the Balanced Budget Act of 1997 (BBA) requires state Medicaid agencies to perform. DMAS requires that contracted Medicaid MCOs conduct PIPs in accordance with 42 CFR §438.330 (d). PIPs must be designed to achieve significant and sustained improvement in clinical and nonclinical areas of care through ongoing measurement and intervention, and they must be designed to have a favorable effect on health outcomes and member satisfaction. The PIP design requires use of objective quality indicators, implementation of interventions to improve access and quality, evaluation of effectiveness, and activities for increasing or sustaining improvements.

One of the mandatory EQR activities under the BBA requires DMAS to validate PIPs. To meet this validation requirement, DMAS contracted with Health Services Advisory Group, Inc. (HSAG), as the external quality review organization (EQRO). The BBA requires HSAG to assess each MCO’s “strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients” (42 CFR §438.364 [a] [2]).

HSAG, as the State’s EQRO, validates the PIPs through an independent review process. The purpose of a PIP is to assess and improve processes and, thereby, outcomes of care. For such projects to achieve meaningful and sustained improvements in care, and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted, and reported in a methodologically sound manner. To ensure methodological soundness while meeting all state and federal requirements, HSAG follows guidelines established in the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.²²

HSAG’s validation of PIPs includes the following two key components of the quality improvement process:

- Evaluation of the technical structure to determine whether a PIP’s initiation (i.e., topic rationale, PIP team, aims, key driver diagram, and data collection methodology) is based on sound methods and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
- Evaluation of the quality improvement activities conducted. Once designed, a PIP’s effectiveness in improving outcomes depends on thoughtful and relevant intervention determination, intervention testing and evaluation through the use of Plan-Do-Study-Act (PDSA) cycles, and sustainability and spreading of successful change. This component evaluates how well the MCO executed its quality improvement activities and whether the desired aim was achieved and sustained.

The goal of HSAG's PIP validation is to ensure that the MCO and key stakeholders can have confidence that any reported improvement is related and can be linked to the quality improvement strategies and activities conducted during the life of the PIP.

HSAG's methodology for evaluating and documenting PIP findings is a consistent, structured process that provides the MCO with specific feedback and recommendations for the PIP. HSAG uses this methodology to determine the PIP's overall validity and reliability, and to assess the level of confidence in the reported findings.

Each module consists of validation criteria, including using objective quality indicators, implementation of interventions to improve access and quality, evaluation of the effectiveness, and plans for sustaining improvements necessary for successful completion of a valid PIP. Each evaluation element is scored as either Achieved or Not Achieved. Using the PIP Validation Tool and standardized scoring, HSAG reports the overall validity and reliability of the findings as one of the following:

- *High confidence* = the PIP was methodologically sound, the SMART Aim goal was achieved, the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested, and the MCO accurately summarized the key findings.
- *Confidence* = the PIP was methodologically sound, the SMART Aim goal was achieved, and the MCO accurately summarized the key findings. However, some, but not all, quality improvement processes conducted and/or intervention (s) tested were clearly linked to the demonstrated improvement.
- *Low confidence* = (a) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (b) the SMART Aim goal was achieved; however, the quality improvement processes conducted and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- *Reported PIP results were not credible* = The PIP methodology was not executed as approved.

Conducting Annual Independent Review of Access, Quality, and Timeliness of Care §438.350

The provision of EQR activities is a core feature of Virginia's Medicaid managed care quality initiative. DMAS is required to provide for three mandated EQR activities for the managed care MCOs, as follows:

- 1) Validate a sample of each MCO's performance measures annually.
- 2) Validate two or more PIPs for each MCO annually.
- 3) Provide comprehensive review of MCO compliance with federal and State operational standards once every three years.

These and other Medicaid managed care quality assessment activities are conducted for DMAS by an EQRO. DMAS contracts with a quality improvement organization (QIO) to serve as the EQRO for Virginia. Consistent with CMS guidance, the EQRO conducts these mandated activities using CMS published protocols.

Identifying, Evaluating, and Reducing Health Disparities

DMAS uses two approaches for identifying members at high risk for health disparities:

Population Level

At the population level, DMAS is partnering with the Virginia Department of Health, via the Office of Health Equity (OHE) to identify the at-risk populations. Then DMAS collaborates with the OHE on its many initiatives to reduce health disparities including:

1. Analyze data to characterize inequities in health and healthcare, their geographic distribution (e.g., neighborhood, rural, inner city), and their association with social determinants of health; and identify high-priority target areas.
2. Promote equitable access to quality health care and providers.
3. Empower communities to promote health equity.
4. Influence health, healthcare, and public policy in order to promote health equity (“health equity in all policies”).
5. Enhance the capacity of public health and our partners to promote health equity.

MCO Level

At the level of the individual Medicaid or CHIP enrollee, CCC Plus is developing methods to stratify the data by high-risk disparate populations during DMAS’s internal analysis of performance measure data, to identify whether any subset of the population is negatively or positively impacted. As at the population level, DMAS collaborates with the OHE on its many initiatives to reduce health disparities.

Using Performance Incentive Awards and Intermediate Sanctions to Drive Improvement

Intermediate Sanctions 42 CFR §438.340 (b) (7)

Even though DMAS cultivates a culture of collaboration with the MCOs, DMAS recognizes the importance of having a Medicaid/CHIP managed care delivery system that is firmly accountable to provide accessible, timely, and quality focused health care. The contract between the State and each MCO is designed to delineate the regulatory and state-specific performance expectations of the MCO. Even further, it is DMAS’s responsibility to monitor each MCO’s compliance with the contract and to respond promptly and effectively if an MCO fails to meet certain standards.

DMAS Intermediate Sanctions Policy

DMAS has developed an intermediate sanctions policy that is based on Section 1932(e)(1)(A) of the Social Security Act (the Act). Accordingly, intermediate sanctions may be imposed if the managed care organization:

- Fails to substantially provide medically necessary items and services that are required (under law or under such organization’s contract with the State) to be provided to an enrollee covered under the contract;
- Imposes premiums or charges enrollees in excess of the premiums or charges permitted by Title XIX of the Act;
- Acts to discriminate among enrollees on the basis of their health status or requirements for health care services, including expulsion or refusal to re-enroll an individual, except as permitted by Title XIX of the Act, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the entity by eligible individuals whose medical condition or history indicates a need for substantial future medical services;
- Fails to comply with the physician incentive requirements under Section 1903(m)(2)(A)(x) of the Act; or,
- Misrepresents or falsifies information furnished to the Secretary of Health and Human Services, State, enrollee, potential enrollee, or health care provider.

In addition to intermediate sanctions, there are provisions in the MCO contract that address sanctions if an MCO repeatedly fails to meet certain standards and finally, provisions that give DMAS the authority to terminate the contract.

Where DMAS determines that the MCO has failed to submit required data or meet a data quality benchmark on any metric of the Data Quality Scorecard, the Department will send a notice of noncompliance. The Department reserves the right to apply penalties for noncompliance.

DMAS stands prepared to impose sanctions quickly, carefully, appropriately, and when necessary and in the best interest of eligible Virginians, should any circumstances arise. Intermediate sanctions include:

- Civil money penalties.
- The appointment of temporary management.
- Permitting individuals enrolled with the MCO to terminate enrollment without cause, and notifying such individuals of such right to terminate enrollment.
- Suspension or default of all enrollment of individuals.
- Suspension of payment to the MCO.

Performance Incentive Award (PIA) Program for Medallion and FAMIS

Beginning FY 2016, DMAS implemented a Performance Incentive Award (PIA) program. The PIA program builds on a pilot program established in FY 2015 and is based on criteria established by DMAS using three HEDIS measures and three administrative measures designed to measure managed care quality. DMAS has determined that the selected six measures are instrumental in achieving the goals and objectives of managed care quality improvement for Virginia.

The PIA (or penalty) will be relative to performance among the contracting health plans. The maximum amount at risk for each MCO is 0.15 percent of the total annual MCO capitation amount (i.e., per member per month [PMPM] capitation rate times the total annual member months), and the maximum award is 0.15 percent of the total annual MCO capitation amount. Total awards for all MCOs will equal total penalties for all MCOs. Because the PIA is designed as a “zero sum” approach where the total MCOs’ awards are equal to the total MCOs’ penalties, the end result is a gain or a loss or no change for each payer (MCO) and no gain or loss for the purchaser (DMAS). This complies with 42 CFR §438.6 (b) (2).

The structure of the PIA follows the HEDIS reporting year time frame. HEDIS 2018, for instance, reflects services provided in calendar year 2017. The three administrative measures are based on the monthly reporting deliverables received by the Department from July 1 to June 30 of each measurement year. DMAS anticipates that PIA report cards for each health plan will be completed by December 31, 2018, for FY 2018. The amount of loss or gain for each MCO is contingent on two factors: 1) MCO performance on each of the six quality measures, and 2) the total capitation paid to each MCO for the fiscal year. The maximum number of points that an MCO can score for any of the six (weighted) measures is three. The measures are as follows:

Three administrative measures:

- Assessments of the foster care population
- MCO claims processing
- Monthly reporting timeliness and accuracy

Three HEDIS measures:

- Percentage of 2-year-olds who are fully immunized (Combo 3)
- Percentage of members with a diagnosis of hypertension whose blood pressure is controlled
- Percentage of pregnant members who received timely prenatal care

Payment or penalties pursuant to the PIA will be distributed by March 2019. This process and the schedule will recur in the following years. Therefore, the FY 2019 PIA will be complete by December 31, 2019, and payment or penalties will be distributed by March 2020. The value of the 0.15 percent maximum PIA or penalty is not reflected in the contract year 2018 capitation rates because total awards for all MCOs will equal total penalties for all MCOs.

Identifying Persons Needing Long-Term Services and Supports and Persons With Special Needs

Coordination and Continuity of Care §438.208 (c) (1)

DMAS contracts with vendors to administer the Virginia Uniform Assessment Instrument that is used to determine eligibility for LTSS. Assessment vendors may include hospitals, social service agencies or other entities overseeing care of members. Additional services for members with special health care needs or who need LTSS are provided through the Commonwealth Coordinated Care Plus (CCC Plus) managed care model.

Under the CCC Plus program, the health plans are asked to stratify members to measure quality for different groups of persons with special needs such as the nursing facility population, waiver population, EPSDT, foster care, early intervention members, and vulnerable subpopulations.

Obtaining Public Comment §438.340 (c) (1) (i)

Medical Care Advisory Committee §438.340 (c) (1) (i)

DMAS has established a Medicaid Physician and Managed Care Liaison Committee (MPMCLC). One of the responsibilities of the committee is to review and provide feedback on the DMAS Quality Strategy. Committee membership includes, but is not limited to, representatives from the following organizations: Virginia Academy of Family Physicians, American Academy of Pediatricians—Virginia Chapter, Virginia College of Emergency Physicians, American College of Obstetrics and Gynecology—Virginia Section, American College of Radiology, Psychiatric Society of Virginia, Virginia Medical Group Management Association, and Medical Society of Virginia. The committee includes representatives from each of the department’s contracted managed care organizations and a representative from the Virginia Association of Health Plans. The committee works with the Department to investigate the implementation of quality, cost-effective health care initiatives, to identify means to increase provider participation in the Medicaid program, to remove administrative obstacles to quality, to explore cost-effective patient care, and to address other matters as raised by the Department or members of the committee. The committee meets semiannually or more frequently if requested by the Department or members of the committee. The Department, in cooperation with the committee, reports on the committee’s activities annually to the Board of Medical Assistance Services and to the Chairmen of the Senate Finance and House Appropriations Committees and the Department of Planning and Budget no later than October 1 each year. The Annual Report to the General Assembly on the Medicaid Physician and Managed Care Liaison Committee, dated October 1, 2017, includes an update on the DMAS Quality Strategy and objectives for provider performance measures (Appendix D).

Beneficiary and Stakeholder Input §438.340 (c) (1) (i)

Internal and external key stakeholders are invited to review the strategy before it is considered “final.” Internal stakeholders include representatives from Health Care Services, Integrated Care, and other DMAS divisions, including Developmental Disabilities and Behavioral Health, and the Office of the Chief Medical Officer.

DMAS spends a significant amount of time obtaining stakeholder feedback on contracts, quality measures, and all aspects of the program. In addition, DMAS seeks public comments through the established web-based system that is used exclusively by state agencies for soliciting public comments. The area for soliciting comments is located within the Commonwealth of Virginia’s Town Hall website at <http://townhall.virginia.gov/>. The final draft was posted on the DMAS website for public comment on October 30, 2017, and written feedback was solicited through November 30, 2017. No public comments were received during this period. DMAS requested additional feedback from internal stakeholders and confirmed there were no further comments as well. Images of the Virtual Town Hall General Notice and General Notice of Closure can be found in Appendix E. The final version of the Quality Strategy was submitted to CMS in early December for review and comment after the public comment period closed.

Consulting With Tribes 438.340 (c) (1) (ii)

DMAS understands that access to the decision-making process regarding the Medicaid and CHIP programs is especially critical for tribes for cultural, treaty, and statutory reasons. Therefore, DMAS's tribal consultation policy follows the federal requirements for tribal consultation. For example, DMAS notifies the tribe in writing at least 60 days prior to the State's submission of any Medicaid or CHIP State plan amendment, waiver request, or proposal for a demonstration project likely to have a direct effect on Indians, Indian health programs, or urban Indian organizations.

The notification describes the purpose of the waiver or renewal and the anticipated impact on tribal members. It also describes a method for appropriate tribal representatives to provide official written comments and questions within an adequate time (at least 30 days) that allows time for DMAS's analysis, consideration of any issues that are raised, and time for discussion between DMAS and tribes responding to the notification. DMAS sent the Pamunkey tribe a copy of the Quality Strategy via email with a request for comment on November 16, 2017 (Appendix F). The tribe had not submitted any feedback by the time the Quality Strategy was submitted to CMS.

Developing, Updating, and Revising the Quality Strategy §438.340 (c) 2

DMAS will update the Quality Strategy every three years if warranted based on each MCO's performance; stakeholder input and feedback; achievement of goals; changes resulting from legislative, State, federal, or other regulatory authority; and/or significant changes to the programmatic structure of the Virginia Medicaid program. In addition, revised editions are published whenever a "significant change" (as defined in the following subsection) occurs during the three years covered by the current edition.

The process used for producing this quality strategy and subsequent revisions relies on a joint effort with the DMAS Quality Steering Committee, inclusive of DMAS's Division of Health Care Services, Integrated Care, and FFS (Office of the Chief Medical Officer). This multifaceted approach began with senior leadership's approval of the Quality Steering Committee project charter. The key milestones for the development of this strategy included:

- Review other states' quality strategies to identify best practices and generate ideas. Crosswalk DMAS's first Quality Strategy and the managed Medicaid regulations to identify gaps and opportunities for improvement.
- Organize internal (DMAS, MCO contracts) and external (CMS, CFR, NCQA) documents for content development. Survey DMAS managers and Medicaid/CHIP MCO managers and quality improvement staff to ensure intent and content of the strategy would be useful to key stakeholders. Incorporate feedback from DMAS managers and subject matter experts on first draft of the strategy.
- Post Notice for public comment for the quality strategy on DMAS's website once it is approved by DMAS senior leadership.
- Address public comments and submit the Quality Strategy to CMS for review and approval.

Clarifying Definition of Significant Change §438.340 (b) 11

DMAS defines a "significant change" that triggers a revision to the Quality Strategy as one that is likely to affect the delivery or measurement of the quality of health care services delivered through the

Medicaid/CHIP managed care delivery system. Federal and State health care reform is creating the need for rapid regulatory and policy changes, many of which may have significant impact on the delivery or measurement of health care received through managed care. Additionally, changes to NCQA standards, which are published annually, may be considered significant. These changes are carefully monitored to ensure the Quality Strategy does not conflict with these public policies.

Changes to formatting, dates, or changes that do not impact the intent or content of the Quality Strategy will be considered “insignificant.”

Reviewing and Evaluating Effectiveness of the Quality Strategy §438.340 (c) (2) (i-ii)

Annual Review

The Quality Strategy is reviewed for its effectiveness annually by the EQRO. The findings are included in the EQRO’s annual technical reports (ATRs) for Medallion 4.0 and CCC Plus on the quality of DMAS’s managed care delivery system. The ATRs are required by CMS and must include an assessment of the State’s Quality Strategy.

Ongoing Review of Performance Improvement

DMAS uses multiple approaches to review the Quality Strategy on an ongoing basis. The MCOs are required to track their own performance ongoing and to report achievements and opportunities for improvement in an MCO quality evaluation, which is submitted annually to DMAS by each MCO.

For areas that require a specialized focus and targeted performance improvement interventions, DMAS requires the MCOs to conduct ongoing performance improvement projects (PIPs). The purpose of PIPs is to achieve significant, sustained improvement in both clinical and nonclinical areas through ongoing measurements and intervention. PIPs provide a structured method of assessing and improving processes, and thereby outcomes, of care for the population that an MCO serves. DMAS’s EQRO validates the MCOs’ PIPs annually and submits to DMAS validation findings, conclusions, and recommendations to improve PIP interventions and outcomes for the following year’s PIP review cycle. Throughout the year, the MCOs are required to conduct and report on interim measurements to determine if PIP interventions are successful. The MCOs report on their intervention evaluation efforts during monthly and/or quarterly meetings with the EQRO. The ongoing evaluation and exchange of information regarding PIP interventions and barriers enable the MCOs to target performance improvement efforts in specified areas. DMAS uses the results of the PIP validation findings to assess each MCO’s achievement of goals and to make modifications to the Quality Strategy based on the MCOs’ performance, if necessary.

Contract Compliance

DMAS monitors each MCO’s compliance with its contract, and with the goals and objectives identified in the Quality Strategy, via an internal quality assurance program (IQAP) on-site review of compliance with various quality assessment/improvement standards. DMAS’s EQRO conducts IQAP reviews at least once every three years. The purpose of the reviews is to determine an MCO’s understanding and application of BBA and contractually required standards from a review of documents, observations, and interviews with key health plan staff, as well as file reviews conducted during the on-site evaluation. The IQAP review includes an assessment of each MCO’s quality improvement (QI) structure. This structure is necessary to facilitate quality improvement and ongoing assessment of performance measures and PIPs. This enables DMAS and the MCOs to assess each MCO’s performance in achieving quality goals and objectives identified

in the Quality Strategy. The IQAP report enables the MCOs to implement remediation plans to correct any areas of deficiency found during the IQAP review. The report also helps DMAS determine each MCO's compliance with the contract and identify areas of the contract that need to be modified or strengthened to ensure that an MCO complies with the standards.

Posting the Quality Strategy Review to the Website

§438.340 (c) (2) (ii)

DMAS reviews and updates the Quality Strategy as needed, but not less than once every three years. This review includes an evaluation of the effectiveness of the Quality Strategy in place during the three previous years. DMAS will make the results of the review available on the DMAS's website at <http://www.dmas.virginia.gov/default.aspx> as required by §438.10(c)(3). Additionally, DMAS ensures that the EQRO provides recommendations on how the Commonwealth of Virginia can target goals and objectives in this Quality Strategy to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid recipients in the annual technical report.

Incorporating Recommendations

DMAS provides written acknowledgement to all stakeholders that provide written feedback during the public comment period. All recommendations are shared with appropriate departments within DMAS for consideration and are incorporated into the final version of the Quality Strategy as judged appropriate by DMAS. The recommendations and responses from DMAS are included as Appendix E into the final version of the Quality Strategy that is posted on the DMAS website.

Submitting the Quality Strategy to CMS

§438.340 (c) (3) (i-ii)

DMAS submits both updates and revisions of the Quality Strategy to CMS for review and approval after public comment has been received and incorporated. Feedback received from CMS is included in Appendix G.

Interim Revised Editions

If significant changes are made to this updated 2017–2019 edition of the Quality Strategy, the revision(s) will include a public comment period, CMS review and approval, and a resultant new edition. Insignificant changes would not warrant the need for a new edition.

Posting the Final CMS-Approved Edition on the Website

§438.340 (d)

After review by CMS, DMAS provides members, providers, and other internal/external stakeholders access to the organization's Quality Strategy through posting the final version on DMAS's Virginia Medicaid portal, website, and other communication portals. The final version of the DMAS Quality Strategy can be found on the DMAS website at: http://www.dmas.virginia.gov/Content_attachments/mc/mc-va1.pdf.

Overview of Previous Quality Strategy

In December 2015, DMAS published Addendum I to the second edition of the Virginia DMAS Managed Care Quality Strategy 2011-2015. This addendum was a companion document to the second edition of the Quality Strategy and was not intended to replace or deviate from the state Vision and Mission. The addendum further expressed key structural features of Virginia's Medicaid and CHIP managed care quality that were expected to continue and remain into the next iteration of the Quality Strategy. The effectiveness of the previous Quality Strategy objectives is summarized below:

Medicaid Managed Care Quality Collaborative

The collaborative has been active for more than a decade and continues to be the main platform for MCOs, EQRO, and DMAS to share lessons learned, best practices, and potential solutions to common opportunities for improvement. The collaborative is facilitated by DMAS Quality Improvement staff and meets four times per year in Richmond. The collaborative has continued to be recognized as the pillar for managed care quality.

Accreditation

Virginia was one of the first states to require Medicaid MCOs to achieve and maintain accreditation from NCQA. As of 2017, all six MCOs contracted with Medallion 3.0 held accredited or commendable NCQA accreditation status. Four of six MCOs contracted with CCC Plus in 2017 have an accredited or commendable NCQA accreditation status, and the remaining two MCOs who are new to the Virginia Medicaid product line are in the process of obtaining their health plan accreditation through NCQA.

When the Medallion 4.0 contracts are awarded, NCQA accreditation will be required.

Core Measures Reporting

In December 2015, CMS published the 2016 Updates to the Child and Adult Core Health Care Quality Measure Sets. DMAS reports performance on core sets of health care quality measures used to assess the quality of health care provided to children and adults enrolled in Medicaid and CHIP, in addition to NCQA HEDIS measures and other metrics DMAS utilizes on other projects. DMAS and the MCOs continue to focus on and report HEDIS measures that are considered priority by the Medicaid Managed Care Quality Collaborative.

Additional Activities Taken to Improve Effectiveness

- This third edition of the Virginia DMAS Managed Care Quality Strategy integrates and aligns the goals and objectives for the Medallion 3.0/4.0, CCC/CCC Plus, and Fee-For-Service Medicaid programs.

Feedback received from CMS on the second edition of the Quality Strategy resulted in the evolution of the stated quality goals to include actionable and measurable objectives and time frames. Furthermore, the improvement targets are based on absolute benchmarks.

Deeming



State Fiscal Year 2017 Deeming Review

November 2016



Executive Summary

Introduction

Health Services Advisory Group, Inc. (HSAG), is contracted with the Virginia Department of Medical Assistance Services (DMAS) to provide external quality review (EQR) services for the Commonwealth of Virginia Medicaid managed care program. As part of these EQR services, DMAS requested that HSAG develop a strategy and recommendations for refining the “deeming” option that DMAS implemented in state fiscal year (SFY) 2014 for its contracted managed care organizations (MCOs). Deeming is an option afforded by federal regulations to states that allows for information obtained from a Medicare or private accreditation review to be used to demonstrate MCO compliance with one or more of the EQR activities described in 42 CFR §438.358(b)(1)(i) through (iii), relating to the validation of performance improvement projects, validation of performance measures, and compliance review when the required conditions are met.

In preparation of the SFY 2017 comprehensive administrative reviews of the MCOs, DMAS requested that HSAG provide a comparison of the 2016 National Committee for Quality Assurance (NCQA) Medicaid Managed Care standards against the 2014 and 2015 NCQA Medicaid Managed Care standards to measure the degree to which the standards have changed over the three-year period. Results of the comparison indicated that updates to the NCQA Medicaid Managed Care standards were minimal between years 2014 and 2016. Based on results of the comparison, HSAG completed a review of the 2016 NCQA health plan standards to identify areas of overlap with the deemable Code of Federal Regulations (CFR) and develop a report with findings and recommendations. To minimize duplicative areas of review, recommendations proposed to DMAS will be based on the evaluation

Background

The Balanced Budget Act of 1997 (BBA) requires states contracting with MCOs for the provision of health care services to Medicaid beneficiaries to comply with the U.S. Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) regulations outlined in CFR, Title 42, Public Health, Part 438, Managed Care. States must ensure that they arrange for annual, external, independent reviews of the quality, timeliness, and accessibility of services provided by MCOs to enrolled consumers.

An external quality review may consist of mandatory and optional activities as specified by 42 CFR §438.358. One of the mandatory activities (to conduct an assessment once in a three-year period of an MCO’s compliance with standards established by the state to comply with the standards set forth in Subpart D of §438 and the quality assessment and performance improvement requirements described in 42 CFR §438.330 under Subpart E of §438.42 CFR §438.360) gives states the option to use information obtained from a Medicare or private accreditation review to demonstrate MCO compliance with the aforementioned standards. MCOs may be “deemed” compliant when these standards reviewed by an accrediting organization are duplicative of the state’s standards as follows for the 2017 comprehensive operational systems review:

Subpart D:

Access Standards

- §438.206, Availability of Services
- §438.207, Assurances of Adequate Capacity and Services
- §438.208, Coordination and Continuity of Care
- §438.210, Coverage and Authorization of Services

Structure and Operations Standards

- §438.214, Provider Selection
- §438.218, Enrollee Information
- §438.224, Confidentiality
- §438.226, Enrollment and Disenrollment
- §438.228, Grievance Systems
- §438.230, Subcontractual Relationships and Delegation

Measurement and Improvement Standards

- §438.236, Practice Guidelines
- §438.240, Quality Assessment and Performance Improvement Program (moved under §438.330 Subpart E in the 2016 updated managed care rule)
- §438.242, Health Information Systems

Certain requirements must be met for a state to exercise the deeming option to prevent duplication of reviews of its contracted MCOs:

- 1) The MCO must be in compliance with the applicable Medicare standards established by CMS, as determined by CMS or its MCO for Medicare, or it must have obtained accreditation from a private accrediting organization recognized by CMS as applying standards at least as stringent as the procedures applying to Medicare in 42 CFR §422.158.
- 2) The Medicare or private accreditation review standards are comparable to standards established through the EQR protocols in 42 CFR §422.158 for the EQR activities described in 42 CFR §438.358(b)(1)(i) through (iii).
- 3) The MCO must provide to the state all the reports, findings, and other results of the Medicare or private accreditation review activities applicable to the standards for the EQR activities. The state must in turn provide the results to the external quality review organization (EQRO).
- 4) The state must identify in its quality strategy the standards for which it will use information from a Medicare or private accreditation organization review and the rationale for why it is duplicative.

Methodology for Determining Comparability

The standards of the private accrediting agency, NCQA, were used for this evaluation because all of the Medicaid MCOs in the Commonwealth of Virginia are accredited by NCQA. HSAG used accreditation standards that are applicable to the federal standards and will exclude standards and elements pertaining to an MCO's operations such as case management, disease management, and call center operations.

The 2016 NCQA Medicaid Managed Care Crosswalk and Code of Federal Regulations were used as resources by HSAG to determine comparability. HSAG assessed whether each accreditation standard met the relevant regulation in the CFR in its entirety or if parts of the standard met the CFR. If an accreditation standard met only part of a CFR, HSAG determined the percentage of the CFR the standard met.

HSAG has provided a summary table of NCQA standards that HSAG determined to be 100 percent comparable to the CFRs; a table view of HSAG's designation of the CFR requirements compared to NCQA standards; NCQA crosswalk tables detailing results of HSAG's deeming evaluation; and comparative deeming findings of the SFY 2014 and SFY 2017 deeming reviews.

HSAG used the CFRs as the authoritative source of requirements against which accreditation standards and Medicare regulations/standards are compared. The NCQA crosswalk has not been formally approved by CMS. However, NCQA submitted their crosswalks to CMS for review and worked closely with CMS during the development of their respective crosswalks.

To prepare for and complete each crosswalk, HSAG performed a comprehensive review of the NCQA Medicaid crosswalks and the CFRs set forth in Subpart D of §438. HSAG created a crosswalk table between the relevant NCQA standards and the CFRs listed in the regulatory requirements section above. HSAG used the crosswalk information to determine the percentage of comparability of NCQA standards to regulations in the CFRs and identify those CFRs that CMS allows to be eligible for deeming.

To ensure standards align with the upcoming SFY 2017 comprehensive operational systems review and the CFRs referenced in the most recent NCQA Medicaid crosswalk, HSAG utilized CFRs in place prior to May 2016, which is when CMS revised many of its regulations. However, for informational purposes, HSAG has referenced those CFRs that have changed significantly due to the May 2016 revisions (e.g., changed citations, are no longer included in one of the referenced subparts).

Findings

As demonstrated by Table 1, HSAG compared the CFR requirements eligible for deeming with NCQA, standards to determine if any of the current standards produced 100 percent comparability with the CFR in SFY 2017.

Table 1—Comparison of the CFR to NCQA Standards and CFRs		
CFR Area	Number of CFR Requirements Eligible for Deeming	Number of NCQA Standards 100% Comparable with CFRs
42 CFR PART 438—Managed Care		
Subpart D—MCO Standards		
Subpart E—Quality Measurement and Improvement		
Availability of Services	11	7
Assurances of Adequate Capacity and Services	5	1
Coordination and Continuity of Care	10	0
Coverage and Authorization of Services	7	3
Provider Selection	6	1
Confidentiality	1	1
Grievance System	0	0
Subcontractual Relationships and Delegation	5	4
Practice Guidelines	4	1
Health Information Systems	2	0
Quality Assessment and Performance Improvement Program	7	2
Totals	58	20

The summary of SFY 2017 totals can be found in Appendix A. Tables listing the exact standards with 100 percent comparability can be found in Appendix B. Appendix B also contains a listing of the NCQA standards that did not yield a 100 percent match with the CFRs.

The NCQA comparison worksheet contained designations for deeming of 42 CFR §438.114 Coverage and Authorization of Services for emergency and post-stabilization treatment. These regulations include requirements for coverage and authorization of services; however, CMS does not consider 42 CFR §438.114 as one of the CFRs that can be considered for deeming. HSAG did not find any of the standards in 42 CFR §438.114 that yielded a 100 percent match with the CFR requirements, and the findings from the comparison of 42 CFR §438.114 to the organization crosswalks are included in Appendix B and Appendix C.

Recommendations

HSAG recommends that all the standards found to be 100 percent comparable with the Medicaid CFRs be eligible for deeming during the SFY 2017 comprehensive operational systems review of the DMAS MCOs, with the following caveats:

- DMAS should require that the MCOs receive full (100 percent) compliance with the applicable accreditation element, standard, and/or CFR.
- An NCQA standard should not be eligible for deeming unless the standard is 100 percent compliant with the Medicaid CFR.

Appendix B. References

References

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Appendix C. DMAS Quality Strategy and Regulatory Reference Crosswalk

Table A-1—Managed Care Code of Federal Regulations—Crosswalk to Managed Care State Quality Strategy

Regulatory Reference	Overview of Requirement	Corresponding Page Reference, Document, or Comment
§438.10 (c) (3)	<p>Each State, enrollment broker, and MCO entity must provide all required information in this section to enrollees and potential enrollees in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees.</p> <p>(2) The State must utilize its beneficiary support system required in §438.71.</p> <p>(3) The State must operate a Web site that provides the content, either directly or by linking to individual MCO entity Web sites, specified in paragraphs (g), (h), and (i) of this section.</p>	DMAS Quality Strategy—pg. 47
§438.62 (b) (3)	<p>The State must make its transition of care policy publicly available and provide instructions to enrollees and potential enrollees on how to access continued services upon transition. At a minimum, the transition of care policy must be described in the quality strategy, under §438.340, and explained to individuals in the materials to enrollees and potential enrollees, in accordance with §438.10.</p>	DMAS Quality Strategy—pgs. 20–24
§438.68	<p>State that contracts with an MCO to deliver Medicaid services must develop and enforce network adequacy standards that include time and distance standards for provider types that include adult and pediatric primary care; OB/GYN; behavioral health; adult and pediatric specialist; hospital; pharmacy; and pediatric dental. Network adequacy standards must include all geographic areas covered by the managed care program and must consider, at a minimum, the following elements. Anticipated enrollment, expected utilization, characteristics and health care needs of specific Medicaid populations, the numbers and types of providers required to furnish the services, the numbers of providers that are no longer accepting new Medicaid patients, geographic location of providers with consideration to time, distance, means of transportation ordinarily used by Medicaid enrollees, language proficiency of network providers for enrollee’s preferred language, provider accessibility and accommodation standards and cultural competence for Medicaid enrollees with special needs, provider capabilities for triage lines, telemedicine, e-visits, and/or other evolving healthcare technology solutions.</p>	<p>DMAS Quality Strategy—pgs. 16–19</p> <p>CCC Plus MCO Contract for Managed Long Term Services and Supports, Section 8.0 Provider Network Management</p> <p>(Future) Medallion 4.0 Contract.</p> <p><i>Medallion 3.0 Contract, Section 3. Access to Care and Network Standards complies with standards for contracts in effect prior to July 1, 2018.</i></p>

Regulatory Reference	Overview of Requirement	Corresponding Page Reference, Document, or Comment
§438.206 (a)	<p>Each State must ensure that all services covered under the State plan are available and accessible to enrollees of MCOs in a timely manner. The State must also ensure that MCO provider networks for services covered under the contract meet the standards developed by the State in accordance with §438.68.</p>	<p>DMAS Quality Strategy—pgs. 18–19</p> <p>CCC Plus MCO Contract for Managed Long Term Services and Supports, Section 8.0 -Provider Network Management and Section 9.0 - Access to Care Standards</p> <p>(Future) Medallion 4.0 Contract</p> <p><i>Medallion 3.0 Contract, Section 3. Access to Care and Network Standards complies with standards for contracts in effect prior to July 1, 2018.</i></p>
§438.206 (b)	<p>The State must ensure, through its contracts, that each MCO consistent with the scope of its contracted services, meets the following requirements:</p> <ol style="list-style-type: none"> (1) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities. (2) Provides female enrollees with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist. (3) Provides for a second opinion from a network provider, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee. (4) If the provider network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO must adequately and timely cover these 	<p>DMAS Quality Strategy—pgs. 18-20</p> <p>CCC Plus MCO Contract for Managed Long Term Services and Supports, Section 8.0 -Provider Network Management, and Section 9.0 – Access to Care Standards</p> <p>(Future) Medallion 4.0 Contract</p> <p><i>Medallion 3.0 Contract, Section 3. Access to Care and Network Standards complies with standards for contracts in effect prior to July 1, 2018.</i></p>

Regulatory Reference	Overview of Requirement	Corresponding Page Reference, Document, or Comment
	<p>services out of network for the enrollee, for as long as the MCO’s provider network is unable to provide them.</p> <p>(5) Requires out-of-network providers to coordinate with the MCO for payment and ensures the cost to the enrollee is no greater than it would be if the services were furnished within the network.</p> <p>(6) Demonstrates that its network providers are credentialed as required by §438.214.</p> <p>(7) Demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services.</p>	
<p>§438.206 (c)</p>	<p>The State must ensure that each contract with a MCO complies with the following requirements.</p> <p>(1) <i>Timely access.</i> Each MCO, PIHP, and PAHP must do the following:</p> <ul style="list-style-type: none"> (i) Meet and require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. (ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS, if the provider serves only Medicaid enrollees. (iii) Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. (iv) Establish mechanisms to ensure compliance by network providers. (v) Monitor network providers regularly to determine compliance. (vi) Take corrective action if there is a failure to comply by a network provider. <p>(2) <i>Access and cultural considerations.</i> Each MCO participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.</p> <p>(3) <i>Accessibility considerations.</i> Each MCO must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.</p>	<p>DMAS Quality Strategy—pgs. 18–19</p> <p>CCC Plus MCO Contract for Managed Long Term Services and Supports, Section 8.0 -Provider Network Management, and Section 9.0—Access to Care Standards</p> <p>(Future) Medallion 4.0 Contract</p> <p><i>Medallion 3.0 Contract, Section 3. Access to Care and Network Standards complies with standards for contracts in effect prior to July 1, 2018.</i></p>

Regulatory Reference	Overview of Requirement	Corresponding Page Reference, Document, or Comment
<p>§438.208 (c) (1)</p>	<p>The State must implement mechanisms to identify persons who need LTSS or persons with special health care needs to MCOs, PIHPs and PAHPs, as those persons are defined by the State. These identification mechanisms—</p> <ul style="list-style-type: none"> (i) Must be specified in the State's quality strategy under §438.340. (ii) May use State staff, the State's enrollment broker, or the State's MCOs, PIHPs and PAHPs. 	<p>DMAS Quality Strategy—pgs. 42-43</p> <p>CCC Plus MCO Contract for Managed Long Term Services and Supports, Section 5.0—CCC Plus Model of Care</p> <p><i>Medallion 3.0 Contract, Section 7.7 Assessments and Additional Requirements for Members with Special Health Care needs complies with standards for contracts in effect prior to July 1, 2017.</i></p>
<p>§438.236</p>	<p>The State must ensure, through its contracts, that each MCO adopts practice guidelines that meet the following requirements:</p> <ul style="list-style-type: none"> (1) Are based on valid and reliable clinical evidence or a consensus of providers in the particular field. (2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees. (3) Are adopted in consultation with contracting health care professionals. (4) Are reviewed and updated periodically as appropriate. <p>The State must ensure that each MCO disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.</p> <p>The State must ensure, through its contracts, that each MCO's decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.</p>	<p>DMAS Quality Strategy—pg. 20</p>

Regulatory Reference	Overview of Requirement	Corresponding Page Reference, Document, or Comment
<p>§438.330 (c)</p>	<p>The State must—</p> <ul style="list-style-type: none"> (i) Identify standard performance measures, including those performance measures that may be specified by CMS relating to the performance of MCOs; and (ii) In addition to the measures, in the case of an MCO providing long-term services and supports, identify standard performance measures relating to quality of life, rebalancing, and community integration activities for individuals receiving long-term services and supports. <p>The State must require that each MCO annually—</p> <ul style="list-style-type: none"> (i) Measure and report to the State on its performance, using the standard measures required by the State. (ii) Submit to the State data, specified by the State, which enables the State to calculate the MCO's performance using the standard measures identified by the State; or (iii) Perform a combination of the activities described in paragraphs (c) (2) (i) and (ii). 	<p>DMAS Quality Strategy—pgs. 31–35</p> <p>CCC Plus MCO Contract for Managed Long Term Services and Supports, Section 10.0 Quality Management and Improvement</p> <p>Medallion 4.0 Contract</p> <p>Medallion 3.0 Contract, Section 8—Quality Improvement and Oversight</p>
<p>§438.330 (d)</p>	<p>The State must require that MCOs conduct performance improvement projects, including any performance improvement projects required by CMS that focus on both clinical and nonclinical areas.</p> <p>Each performance improvement project must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and must include the following elements:</p> <ul style="list-style-type: none"> (i) Measurement of performance using objective quality indicators. (ii) Implementation of interventions to achieve improvement in the access to and quality of care. (iii) Evaluation of the effectiveness of the interventions based on the performance measures. (iv) Planning and initiation of activities for increasing or sustaining improvement. <p>The State must require each MCO to report the status and results of each project conducted to the State as requested, but not less than once per year.</p>	<p>DMAS Quality Strategy—pgs. 38-39</p> <p>CCC Plus MCO Contract for Managed Long Term Services and Supports, Section 10.0 Quality Management and Improvement</p> <p>Medallion 4.0 Contract</p> <p>Medallion 3.0 Contract, Section 8—Quality Improvement and Oversight</p>

Regulatory Reference	Overview of Requirement	Corresponding Page Reference, Document, or Comment
	The State may permit an MCO exclusively serving dual eligibles to substitute an MA Organization quality improvement project conducted under §422.152 (d) for one or more of the performance improvement projects otherwise required under this section.	
§438.330 (e)	<p>The State must review, at least annually, the impact and effectiveness of the quality assessment and performance improvement program of each MCO entity described in §438.310 (c) (2). The review must include—</p> <ul style="list-style-type: none"> (i) The MCO's entity's performance on the measures on which it is required to report. (ii) The outcomes and trended results of each MCO's performance improvement projects. (iii) The results of any efforts by the MCO to support community integration for enrollees using long-term services and supports. <p>(2) The State may require that an MCO entity described in §438.310 (c) (2) develop a process to evaluate the impact and effectiveness of its own quality assessment and performance improvement program.</p>	<p>DMAS Quality Strategy—pgs. 38-40, 46</p> <p>CCC Plus MCO Contract for Managed Long Term Services and Supports, Section 10.0 Quality Management and Improvement</p> <p>Medallion 4.0 Contract</p> <p>Medallion 3.0 Contract, Section 8—Quality Improvement and Oversight</p>
§438.340 (a)	Each State contracting with an MCO must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by the MCO entity.	DMAS Quality Strategy—entire document
§438.340 (b) (1)	At a minimum, the State's quality strategy must include the State-defined network adequacy and availability of services standards for MCOs required by §438.68 and §438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with §438.236.	DMAS Quality Strategy—pg. 20
§438.340 (b) (2)	At a minimum, the State's quality strategy must include the State's goals and objectives for continuous quality improvement which must be measurable and take into consideration the health status of all populations in the State served by the MCO.	DMAS Quality Strategy—pgs. 2-4
§438.340 (b) (3) (i)	At a minimum, the State's quality strategy must include a description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO with which the State contracts, including but not limited to, the performance measures reported in accordance with §438.330 (c). The State must identify which quality	DMAS Quality Strategy—pgs. 31-32

Regulatory Reference	Overview of Requirement	Corresponding Page Reference, Document, or Comment
	measures and performance outcomes the State will publish at least annually on the Web site required under §438.10 (c) (3).	
§438.340 (b) (3) (i)	At a minimum, the State's quality strategy must include a description of the performance improvement projects to be implemented in accordance with §438.330 (d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO.	DMAS Quality Strategy—pgs. 38-39
§438.340 (b) (4)	At a minimum, the State's quality strategy must include the arrangements for annual, external independent reviews, in accordance with §438.350, of the quality outcomes and timeliness of, and access to, the services covered under each MCO [described in §438.310 (c) (2)] contract.	DMAS Quality Strategy—pgs. 39-40
§438.340 (b) (5)	At a minimum, the State's quality strategy must include a description of the State's transition of care policy required under §438.62 (b) (3).	DMAS Quality Strategy—pgs. 20-21
§438.340 (b) (6)	At a minimum, the State's quality strategy must include the State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. States must identify this demographic information for each Medicaid enrollee and provide it to the MCO, at the time of enrollment. For purposes of this paragraph (b)(6), "disability status" means whether the individual qualified for Medicaid on the basis of a disability.	DMAS Quality Strategy—pgs. 28, 43
§438.340 (b) (7)	At a minimum, the State's quality strategy must include for MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this part.	DMAS Quality Strategy—pgs. 40-42
§438.340 (b) (9)	At a minimum, the State's quality strategy must include the mechanisms implemented by the State to comply with §438.208 (c) (1) (relating to the identification of persons who need long-term services and supports or persons with special health care needs).	DMAS Quality Strategy—pg. 43
§438.340 (b) (10)	At a minimum, the State's quality strategy must include the information required under §438.360 (c) (relating to non-duplication of EQR activities)	DMAS Quality Strategy—pg. 24
§438.340 (b) (11)	At a minimum, the State's quality strategy must include the State's definition of a "significant change" for the purposes of paragraph (c) (3) (ii) of this section.	DMAS Quality Strategy—pg. 45
§438.340 (c) (1) (i) & (ii)	In drafting or revising its quality strategy, the State must make the strategy available for public comment before submitting the strategy to CMS for review, including:	DMAS Quality Strategy—pg. 47

Regulatory Reference	Overview of Requirement	Corresponding Page Reference, Document, or Comment
	<ul style="list-style-type: none"> (i) Obtaining input from the Medical Care Advisory Committee, beneficiaries, and other stakeholders. (ii) If the State enrolls Indians in the MCO, consulting with Tribes in accordance with the State's Tribal consultation policy. 	
§438.340 (c) (2)	Review and update the quality strategy as needed, but no less than once every 3 years.	DMAS Quality Strategy—pg. 47
§438.340 (c) (2) (i)	The quality strategy review must include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years.	DMAS Quality Strategy—pg. 48
§438.340 (c) (2) (ii)	The State must make the results of the quality strategy review available on the Web site required under §438.10 (c) (3).	DMAS Quality Strategy—pg. 47
§438.340 (c) (2) (iii)	Updates to the quality strategy must take into consideration the recommendations provided pursuant to §438.364 (a) (4).	DMAS Quality Strategy—pg. 47
§438.340(c) (3) (i) and (ii)	<p>The State must submit to CMS the following:</p> <ul style="list-style-type: none"> (i) A copy of the initial strategy for CMS comment and feedback prior to adopting it in final. (ii) A copy of the revised strategy whenever significant changes, as defined in the state's quality strategy per paragraph (b) (11) of this section, are made to the document, or whenever significant changes occur within the State's Medicaid program. 	DMAS Quality Strategy—pg. 47
§438.340 (d)	The State must make the final quality strategy available on the Web site required under §438.10 (c) (3).	DMAS Quality Strategy—pg. 47
§438.360 (c)	The State must identify in its quality strategy under §438.340 the EQR activities for which it has exercised the option described in this section, and explain the rationale for the State's determination that the Medicare review or private accreditation activity is comparable to such EQR activities, consistent with paragraph §438.360 (a) (2).	DMAS Quality Strategy—pg. 24

Appendix D. Annual Report on the Medicaid Physician and Managed Care Liaison Committee



COMMONWEALTH of VIRGINIA *Department of Medical Assistance Services*

CYNTHIA B. JONES
DIRECTOR

October 1, 2017

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MEMORANDUM

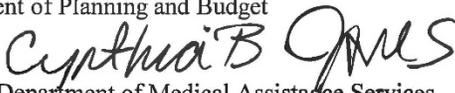
TO: Karen S. Rheuban, M.D.
Chair, Board of Medical Assistance Services

The Honorable Thomas K. Norment, Jr.
Co-Chairman, Senate Finance Committee

The Honorable Emmett W. Hanger, Jr.
Co-Chairman, Senate Finance Committee

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

Daniel Timberlake
Director, Department of Planning and Budget

FROM: Cynthia B. Jones 
Director, Virginia Department of Medical Assistance Services

SUBJECT: Annual Report on the Medicaid Physician and Managed Care Liaison Committee

The 2017 Appropriation Act, Item 306 GGG, requires the Department of Medical Assistance Services shall establish a Medicaid Physician and Managed Care Liaison Committee and the Committee shall establish an Emergency Department Care Coordination work group. The department, in cooperation with the committee, shall report on the committee's activities annually to the Board of Medical Assistance Services and to the Chairmen of the House Appropriations and Senate Finance Committees and the Department of Planning and Budget no later than October 1 each year.

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

CBJ/

Enclosure

pc: The Honorable William A. Hazel, Jr., MD, Secretary of Health and Human Resources

Annual Report to the General Assembly on the Medicaid Physician and Managed Care Liaison Committee

A Report to the Virginia General Assembly

October 1, 2017

Report Mandate:

The 2017 Appropriation Act, Item 306 GGG, states:

“Effective July 1, 2013, the Department of Medical Assistance Services shall establish a Medicaid Physician and Managed Care Liaison Committee (MPMCLC) including, but not limited to, representatives from the following organizations: the Virginia Academy of Family Physicians; the American Academy of Pediatricians – Virginia Chapter; the Virginia College of Emergency Physicians; the American College of Obstetrics and Gynecology – Virginia Section; Virginia Chapter, American College of Radiology; the Psychiatric Society of Virginia; the Virginia Medical Group Management Association; and the Medical Society of Virginia. The committee shall also include representatives from each of the department’s contracted managed care organizations and a representative from the Virginia Association of Health Plans. The committee will work with the department to investigate the implementation of quality, cost-effective health care initiatives, to identify means to increase provider participation in the Medicaid program, to remove administrative obstacles to quality, cost-effective patient care, and to address other matters as raised by the department or members of the committee. The Committee shall establish an Emergency Department Care Coordination work group comprised of representatives from the Committee, including the Virginia College of Emergency Physicians, the Medical Society of Virginia, the Virginia Hospital and Healthcare Association, the Virginia Academy of Family Physicians and the Virginia Association of Health Plans to review the following issues: (i) how to improve coordination of care across provider types of Medicaid “super utilizers”; (ii) the impact of primary care provider incentive funding on improved interoperability between hospital and provider systems; and (iii) methods for formalizing a statewide emergency department collaboration to improve care and treatment of Medicaid recipients and increase cost efficiency in the Medicaid program, including recognized best practices for emergency departments. The committee shall meet semi-annually, or more frequently if requested by the department or members of the committee. The department, in cooperation with the committee, shall report on the committee’s activities annually to the Board of Medical Assistance Services and to the Chairmen of the House Appropriations and Senate Finance Committees and the Department of Planning and Budget no later than October 1 each year.”

About DMAS and Medicaid

DMAS’ mission is to ensure Virginia’s Medicaid enrollees receive high quality and cost effective health care.

Medicaid plays a critical role in the lives of over a million Virginians, providing health care for those most in need. Medicaid enrollees include children, pregnant women, parents and care takers, older adults and individuals with disabilities. Virginians must meet income thresholds and other eligibility criteria before qualifying to receive Medicaid benefits.

Medicaid covers primary and specialty health care, inpatient care, and behavioral health and addiction and recovery treatment services. Medicaid also covers long term services and supports, making it possible for thousands of Virginians to remain in their homes or to access residential and nursing home care.

Quick Medicaid facts:

- Covers 1 in 8 Virginians
- Covers 1 in 3 births and 33% of children
- Supports 2 in 3 nursing facility residents

Virginia Medicaid and Children’s Health Insurance Program (CHIP) are administered by the Department of Medical Assistance Services (DMAS) and are jointly funded by Virginia and the federal government under the Title XIX and Title XXI of the Social Security Act. Virginia generally receives \$1 of federal matching funds for every \$1 Virginia spends on Medicaid.

Background

The Medicaid Physician and Managed Care Liaison (MPMCL) Committee membership is comprised of representatives from the DMAS contracted managed care organizations (MCOs), the Virginia Association of Health Plans, and the physician organizations specified in the budget language referenced above. In January 2017, its membership was broadened to include the perspectives of non-physician providers who care for Medicaid members. Additional representatives from other provider associations including the Virginia Council of Nurse Practitioners, the Virginia Nurses Association, the Virginia Affiliate of the American College of Nurse-Midwives, and the Virginia Academy of Clinical Psychologists were invited to join the Committee. The current membership roster is attached.

The Committee meets biannually.

Current Year Activities

Identifying Committee Priorities

The MPMCL Committee held two face-to-face meetings in the past year, one on January 10, 2017 and another on June 9, 2017. Prior to these full committee meetings, members received an agenda of topics for presentation and discussion.

The following topics were on the agendas:

- Updates of Medallion 3.0 and 4.0 Programs
- Common Core Formulary
- ED Care Coordination Program
- Addiction and Recovery Treatment Services (ARTS) Waiver
- Plan and timeline to develop Virginia Medicaid Quality Strategy
- Public Testimony by Stakeholders

The last topic provided the stakeholders the opportunity to provide public testimony on their specific recommendations to improve outcomes for pregnant women, parents, and children within the Medallion 4.0 program.

Updates of Medallion 3.0 and 4.0 Programs

At the first meeting, the DMAS gave a presentation on both the Medallion 4.0 and Medallion 3.0 programs. Medallion 4.0 is scheduled to begin regional implementation in August 2018, and will cover 761,000 Medicaid and FAMIS members. Aspects of Medallion 3.0

such as expansion of networks, adequate rates, foster care, and telehealth will be incorporated into Medallion 4.0. There will be a stronger member and provider engagement by both DMAS and the health plans. On the member side, DMAS will provide an enrollment broker, member meetings, and expedited enrollment. The plans will be member focused, provide case managers, smartphone apps, financial incentives and outreach teams. On the provider side, DMAS will ensure that the health plans meet network adequacy standards and convene stakeholder meetings. The health plans will provide network management, provider training and service as well as ease of access for members to obtain services.

The regional implementation for Medallion 4.0 will begin on August 1, 2018 in the Tidewater region and finish on December 1, 2018 in the Southwest. There will be concurrent operation of both Medallion 3.0 and 4.0 with Medallion 3.0 being phased out by region through December 31, 2018.

Common Core Formulary

DMAS provided an overview of the Common Core Formulary to the Committee and its implementation in the Commonwealth Coordinated Care (CCC) Plus program. CCC Plus is a new statewide Medicaid Managed Long Term Services and Supports program that will serve approximately 214,000 individuals with complex care needs, through an integrated delivery model, across the full continuum of care. CCC Plus will operate statewide across six regions as a mandatory Medicaid managed care program. The program will focus on improving access, quality, and efficiency through a coordinated delivery system that emphasizes integrated care and value-based, alternative payment models. Regional implementation began on August 1, 2017 in Tidewater. Both CCC Plus and Medallion 4.0 will include the Common Core Formulary.

The Common Core Formulary is a list giving details of drugs that may be prescribed to Medicaid members. The Common Core Formulary includes all the preferred drugs on DMAS' Preferred Drug List (PDL). Preferred drugs are those that are available to members without prior authorization. CCC Plus health plans are required at a minimum to cover all preferred drugs on Virginia Medicaid's PDL without prior authorization. The health plans can add drugs to the Common Core Formulary but cannot remove drugs or place additional restrictions (such as prior authorizations, and quantity limits) for

drugs included on the Common Core Formulary. For drugs not included on the DMAS PDL (e.g., oral oncology drugs, HIV drugs, etc.), each health plan has published a formulary with the plan's covered drugs.

The primary goal of the Common Core Formulary is to ensure continuity of care for members. It should minimize disruptions in drug therapy when a member changes health plans and decrease the administrative burden for prescribers. If a drug is covered under the Fee-for-Service program, it will be covered by all the health plans with no additional restrictions or prior authorization requirements. The Medical Society of Virginia spoke at the end of the presentation to share the following results from a survey of their members:

- Physicians who do not accept Medicaid overwhelmingly cited prior authorizations (PAs) as the primary reason for not accepting Medicaid. Forty-seven percent cite prescription PAs as a reason to not accept Medicaid. Respondents also cited service PAs, the time involved in PAs, reimbursement, and inconsistent administrative requirements.
- Physicians who accept Medicaid cited prior authorizations (52 percent) as the biggest problem they face in treating Medicaid patients; 40 percent identified inconsistent requirements for medications.

Emergency Department Care Coordination Program

DMAS updated the Committee on the Commonwealth's progress since the conclusion of the MPMCL Committee Emergency Department (ED) Care Coordination workgroup in Summer 2016. The Emergency Department Care Coordination program was established in 2017 at the Virginia Department of Health (VDH) to provide a single, statewide technology solution that connects all hospital emergency departments in the Commonwealth to facilitate real-time communication and collaboration between physicians, other health care providers and clinical and care management personnel for patients receiving services in hospital emergency departments, for the purpose of improving the quality of patient care services (re: § 32.1-372)*. Real-time patient visit information from electronic health records will be integrated with the Prescription Monitoring Program and the Advanced Health Directory. The Prescription Monitoring Program is a program used to promote appropriate use of controlled substances for legitimate medical purposes while deterring the misuses, abuse

and diversion of controlled substances. The Advance Health Care Directives Registry is a secure location to store important documents, such as advance health care directives, wills, and physician's orders, that protect an individual's legal rights and ensure that a patient's medical wishes are honored in the event that they become incapacitated and unable to manage their own care. This sharing of information will allow facilities, providers and managed care organizations to identify patient-specific risks, create and share care coordination plans and other care recommendations, and access other clinically beneficial information related to patients receiving services in hospital EDs in the Commonwealth. DMAS and VDH have secured \$3.9 million in federal HITECH funding for the ED Care Coordination and MPM integration technology platform, which will be Medicaid implemented by June 30, 2018 and Medicaid health plans only in the first year.

VDH has contracted with Connect Virginia to oversee the ED Care Coordination project, including convening the ED Care Coordination Council, which includes several representatives who also serve on the MPMCL Committee. The Committee reviewed the goals of the ED Care Coordination project and discussed how they can build upon the new technology solution in the future.

The Committee discussed how the ED Care Coordination Program aims to improve individuals' health by providing information, which assists providers in proactively redirecting their care and connecting them to more appropriate primary care settings. Five percent of patients account for nearly 25 percent of all ED visits in the United States. These high utilizers of the ED services typically do not receive the right care, with the right provider, at the right time – or at the right price. High utilizers often present to the ED with low acuity, chronic health concerns which are less appropriately addressed in the ED, which is designed to care for acute, episodic and emergent health conditions.

Establishing comprehensive primary care relationships with these individuals will reduce ED visits and decrease hospital costs, while providing the right care in the best setting for the patient. Ultimately, a member's relationship with their primary care providers will be supported and strengthened, leading to improved adherence to treatment recommendations and continuity of care. Reinforcement of the proper use of the health care delivery system teaches and enables participants to get their needs met by making informed decisions and directly accessing appropriate care. The MPMCL

Committee members expressed interest in working together after implementation of the technology solution. Specifically, the Committee is interested in using the real-time ED admission data to define shared care coordination models for ED high utilizers. This will include more clearly defining the role of the primary care physician, Emergency Department physician and social worker, and MCO case managers in coordinating care and achieving the best outcomes for members.

Update on Addiction and Recovery Treatment Services (ARTS) Waiver

DMAS shared new information from VDH on the opioid epidemic and provided an update on the DMAS Addiction and Recovery Treatment Services (ARTS) waiver. In 2016, an estimated 1,133 Virginians died of suspected opioid overdoses. Medicaid members are prescribed opioids at twice the rate of non-Medicaid members and are at three to six times the risk of opioid overdose. The Medicaid ARTS benefit was funded in the 2016 Appropriations Act to expand access to addiction treatment by transforming the delivery system for Medicaid members with Substance Use Disorders (SUD).

DMAS's ARTS program launched on April 1, 2017, and is based on the industry standard of the American Society of Addiction Medicine (ASAM) levels of care. The ARTS benefit will provide the full continuum of evidence-based addiction treatment to any of the 1.1 million Medicaid and FAMIS members who need treatment. In addition, the new program transfers the community-based addiction treatment services into the MCOs to promote full integration of physical health, traditional mental health, and addiction treatment services.

CMS approved the Commonwealth for a §1115 waiver that will significantly expand residential SUD treatment capacity. As part of the waiver, CMS requires an evaluation of the effectiveness of the services delivered in terms of clinician ARTS training and service provision as well as Medicaid member health outcomes, health care costs, and service utilization. To that end, a team of researchers from the Virginia Commonwealth University School of Medicine is conducting a robust evaluation of the new ARTS benefit and demonstration.

Plan and timeline for Virginia Medicaid Quality Strategy

DMAS presented on the plan and timeline for development of an agency-wide DMAS Quality Strategy across the Fee-for-Service, CCC Plus, and Medallion managed care programs including the internal DMAS Quality Steering Committee, stakeholder engagement efforts, quality improvement efforts, and the components of a quality strategy. The MPMCL Committee members requested that DMAS send a monthly report to providers with a manageable amount of data on a defined set of measures that reports the provider's performance across all the Medicaid members in their practice. The Committee asked for one report of provider performance on quality measures, not the separate data on different measures that they currently receive from each of the plans. Members requested data that is meaningful and actionable and tells them "What can I do differently tomorrow to improve outcomes for my patients that I'm not doing today?" An example measure would be the number of Medicaid members with HbA1c greater than 9 percent indicating poor control of diabetes and higher risk of complications. This information would allow the providers to reach out to these members to schedule visits to discuss how the members can improve control of their diabetes.

DMAS stated that the agency does not currently have this capability but may in the future after DMAS implements the Enterprise Data Warehouse in Summer 2018. Providers were asked to query their professional associations about what data and quality measures they would like to see on a report in the future. DMAS will use this information from the providers to evaluate whether the new Enterprise Data Warehouse has the capacity to produce these reports.

Public Testimony by Stakeholders

Oral or written public comment with specific recommendations for the Medallion 4.0 program that will improve outcomes for pregnant women, parents, and children was shared by the following provider association representatives: Lauren Bates Rowe, Policy Director, Medical Society of Virginia; Bergen Nelson, MD, Assistant Professor Pediatrics, Children's Hospital of Richmond at VCU, Karen Ronson, MD, Deltaville, VA., Kelly Hill-Walsh, PT, Pediatric Physical Therapist, Early Intervention Professional, Certified, Chair, Virginia Interagency Coordinating Counsel and Dr. Amber Price, DNP, CNM, RN, President Elect Virginia Affiliate American College of Nurse Midwives.

Summary

The MPMCL Committee continues to work closely with the provider community obtaining their input and feedback on upcoming major changes within DMAS and implementation of new programs such as CCC Plus and Medallion 4.0 that will affect both providers and

members. The Committee is continuing to support the ED Care Coordination Initiative, partnering with DMAS on the future development of quality measures for providers, and addressing emerging new issues such as the Opioid Epidemic, which requires collaboration among the provider community and the Managed Care Organizations.

Medicaid Physician & Managed Care Liaison Committee Members 10/2/2017

Organization	Representative	Contact Email
Psychiatric Society of Virginia	Varun Choudhary	vchoudhary@magellanhealth.com
Medical Society of Virginia	Karen Ransone /Cynthia Romero	karen.ransone@rivhs.com/ RomeroCC@EVMS.EDU
Virginia Medical Group Management Association	Bert Wilson	bwilson@dermva.com
INTotal	Mohamed Ally	mohamed.ally@inova.org
Virginia Council of Nurse Practitioners	Cynthia Fagan	Cynthia.Fagan2@va.gov
Optima Family Care	Cynthia Colligan	CLROGERS@sentara.com
Anthem Healthkeepers Plus	David Buchsbaum	David.Buchsbaum@anthem.com
Virginia Association of Health Plans	Stephanie Lynch	stephanie@vahp.org
Kaiser Foundation Health Plan	Cheryl Keys	Cheryl.Keys@kp.org
Virginia College Emergency Physicians	Tamera Barnes	Tcbarnes1@verizon.net
Virginia Nurses Association	Frankye Myers	Frankye.Myers@HCAHealthcare.com
Aetna Better Health	Ira Bloomfield	isbloomfield@cvty.com
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American College of Radiology	John Grizzard	jdgrizzard@vcu.edu
Perinatal Quality Collaborative	Alan Picarillo/Barbara Head	Alan.Picarillo@shcr.com/barbara.head@gmail.com
Voices for Virginia's Children	Margaret Nimo Holland	Margaret@vakids.org
Virginia Department of Health	Adrienne McFadden/Vanessa Walker Harris	Adrienne.McFadden@vdh.virginia.gov/ Vanessa.WalkerHarris@vdh.virginia.gov
Virginia Hospital & Healthcare Association	Chris Bailey	cbailey@vhha.org
Community Pediatrician	Caroline Boone	SharonRich3@aol.com
Pediatric Psychologist	Rosalie Corona	racorona@vcu.edu
Early Childhood Development Expert	Bergen Nelson	bergen.nelson@vcuhealth.org
American College of Nurse Midwives	Amber Price (President Elect)	Amber.Price2@hcahealthcare.com
Virginia Community Healthcare Association	Jim Werth	jwerth@stonemtn.org
United Methodist Family Services	Marcy Johnson	mjohnson@umfs.org
Virginia Healthcare Foundation	Debbie Oswalt	Doswalt@vhcf.org
National Association for Mental Illness	Mira Signer	msigner@namivirginia.org
UVA Center for Health Disparities	Norm Oliver	mno3p@virginia.edu
Virginia Poverty Law Center	Jill Hanken	jill@vplc.org
VICC	Kelly Walsh-Hill	Kellyh63@comcast.net

ANNUAL REPORT ON THE MEDICAID PHYSICIAN AND MANAGED CARE LIAISON COMMITTEE

Medicaid Physician & Managed Care Liaison Committee Members 10/2/2017

Dental Advisory Committee	Teg Brickhouse	tbrickhouse@vccu.edu
Virginia Pharmacists Association	Sam Silek	Samuel.Silek@gmail.com
Virginia Association of Clinical Psychologists VACP	Dr. Jennifer Flaherty	flaherim@evms.edu

Appendix E. DMAS Acknowledgement of Public Comments

Virginia Regulatory Town Hall View General Notice

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Valerie Collier

Agency

Department of Medical Assistance Services

Board

Board of Medical Assistance Services

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General Notice

DMAS Draft 2017- 2019 Medicaid Quality Strategy

Date Posted: 10/11/2017

Expiration Date: 11/30/2017

Submitted to Registrar for publication: YES

[31 Day Comment Forum](#) Will begin on 10/30/2017 and will end at midnight on 11/30/2017

In accordance with the requirements of the federal Medicaid authority, the Centers for Medicare and Medicaid Services (CMS), the Department of Medical Assistance Services gives Notice that the Agency is publishing for public comment a draft of the DMAS 2017-2019 Medicaid Quality Strategy. The Code of Federal Regulations, specifically, 42 CFR §438.340, requires states that contract with Managed Care Organizations (MCOs) to have a written strategy for accessing and improving the quality of managed care services offered to all MCOs. It also requires those states to obtain the input of recipients and other stakeholders in the development of the strategy and to make the strategy available for public comment before adopting as final. The purpose of this Notice is to fulfill that requirement.

A copy of the 2017-2019 Medicaid Quality Strategy may be reviewed on the DMAS web site at the following address:

<http://www.dmas.virginia.gov/default.aspx>

This notice is being made available for comment by interested parties through November 30, 2017. Following this public notice period, DMAS shall take into consideration the public comments received by the Agency and submit the final draft of the DMAS 2017-2019 Medicaid Quality Strategy to the Centers for Medicare & Medicaid Services for approval. Anyone wishing to provide public comment on the DMAS 2017-2019 Medicaid Quality Strategy may submit comments to:

Valerie Collier

Quality Program Manager

Virginia Department of Medical Assistance Services

Division of Health Care Services

Suite 1300, 600 East Broad Street

Richmond, VA 23219

Phone (804) 786-2273

<http://townhall.virginia.gov/L/ViewNotice.cfm?gnid=764>

10/11/2017

Virginia Regulatory Town Hall View General Notice

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10/11/2017

Virginia.gov Agencies | Governor



Public comment forums

Make your voice heard! Public comment forums allow all Virginia's citizens to participate in making and changing our state regulations.

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Secretariat Commerce and Trade

Board for Contractors		
View Comments	Chapter: [18 VAC 50 – 22] Board for Contractors Regulations	Action: Addition of Miscellaneous Specialty Stage: Notice of Intended Regulatory Action Closed: 11/29/17 1 comments Last comment: 11/15/17 10:27 am

Secretariat Health and Human Resources

Board of Medical Assistance Services		
View Comments	DMAS Draft 2017- 2019 Medicaid Quality Strategy	General Notice Closed: 11/30/17 0 comments
State Board of Health		
View Comments	Chapter: [12 VAC 5 – 590] Waterworks Regulations	Action: Amend and update the Waterworks Regulations Stage: Notice of Intended Regulatory Action Closed: 11/29/17 0 comments
Department for Aging and Rehabilitative Services		
View Comments	Chapter: [22 VAC 30 – 120] Adult Services Approved Providers	Action: Revisions to Adult Services Approved Providers Stage: Notice of Intended Regulatory Action Closed: 11/30/17 0 comments
State Board of Social Services		
View Comments	Chapter: [22 VAC 40 – 201] Permanency Services - Prevention, Foster Care, Adoption, and Independent	Action: Amend Permanency Regulation as a Result of 2017 Legislation Stage: Notice of Intended Regulatory Action Closed: 11/30/17 0 comments

	Living	11/29/17
View Comments	Chapter: [22 VAC 40 – 201] Permanency Services - Prevention, Foster Care, Adoption, and Independent Living	Action: Amend Permanency Regulation 2016 Stage: Proposed Closed: 12/1/17 0 comments
View Comments	Chapter: [22 VAC 40 – 211] Resource, Foster and Adoptive Family Home Approval Standards	Action: Amend Foster and Adoptive Home Approval Regulation 2017 Stage: Notice of Intended Regulatory Action Closed: 11/29/17 0 comments
Board of Medicine		
View Comments	Chapter: [18 VAC 85 – 80] Regulations for Licensure of Occupational Therapists	Action: Elimination of CE form and change in title of regulation Stage: Fast-Track Closed: 11/29/17 0 comments

Secretariat Natural Resources

Air Pollution Control Board

View Comments	Chapter: [9 VAC 5 – 5] Public Participation Guidelines	Action: Fast-track revisions to include changes needed as a result of Chapter 795 of the 2012 Acts of Assembly (Revision D17) Stage: Fast-Track Closed: 11/29/17 0 comments
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Secretariat Public Safety and Homeland Security

Criminal Justice Services Board

View Comments	Chapter: [6 VAC 20 – 172] Regulations Relating to Private Security Services Businesses	Action: Amend 6VAC20-172 and 6VAC20-174 to Address Insurance Requirements for Independent Contractors Stage: Final Closed: 11/29/17 0 comments
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Appendix F. Consulting with Tribes

Notice of Opportunity for Tribal Comment - DMAS Draft Quality Strategy - Message (HTML)

File Message ADOBE PDF Tell me what you want to do

Ignore Delete Reply Reply All Forward Meeting IM More Move OneNote Actions Mark Unread Categorize Follow Up Translate Find Related Select Zoom

Thu 11/16/2017 12:32 PM

MB McCormick, Brian (DMAS) <Brian.McCormick@dmas.virginia.gov>
Notice of Opportunity for Tribal Comment - DMAS Draft Quality Strategy

To: Robert Gray
Cc: Valerie Collier

DMAS_Draft Quality_S...
.docx File

Dear Chief Gray:

The Virginia Department of Medical Assistance Services (DMAS) would like to share with members of the Pamunkey tribe of the opportunity to offer public comment on the Agency's draft of the revisions to its Quality Strategy for Managed Care, a copy of which is attached. As is noted in the Executive Summary:

DMAS developed the Quality Strategy to continually improve the delivery of quality health care to all Medicaid and Children's Health Insurance Program (CHIP) recipients served by the Virginia Medicaid managed care and fee-for-service (FFS) programs. DMAS's Quality Strategy provides the framework to accomplish its overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality throughout the Virginia Medicaid and CHIP system. The Quality Strategy promotes the identification of creative initiatives to continually monitor, assess, and improve access to care, and quality, satisfaction, and timeliness of services for Virginia Medicaid and CHIP recipients.

The Agency values your input on this proposal, especially if you determine that it has an impact on the Pamunkey Tribe. If you or any other tribal members wish to provide input on the proposed changes, questions or comments may be sent directly to the DMAS Policy Director, Brian McCormick at Brian.McCormick@dmas.virginia.gov or at one of the two links provided below. DMAS anticipates submitting this draft to the federal Medicaid agency by mid-December, though you are free to comment after that time, as this is a work in progress with the federal government.

Virtual Town Hall: (<https://townhall.virginia.gov/>) (see *Public Comment Forums*, Secretariat: Health and Human Services, Agency: Board of Medical Assistance Services).

DMAS: (<http://www.dmas.virginia.gov/>) (the document is located directly under "What's New" and named *DMAS Draft Quality Strategy Public Comment*).

Thank you very much Chief Gray. I wish you and yours the best for the upcoming holiday season.

Brian McCormick, Director
DMAS Policy Division
600 East Broad Street
Richmond, VA 23219
804-371-8856

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Appendix G. CMS Quality Strategy Review and Approval

Placeholder for addressing CMS feedback and approval.